WORKING FOR A SHARED COMMON PURPOSE – EXPERIENCES OF HEALTH AND SOCIAL CARE INTEGRATION IN WALES

Report

for UNISON Cymru Wales

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FOREWORD

UNISON Cymru/Wales wholly supports the integration of health and social care in Wales based on a whole person centred approach.

UNISON Cymru/Wales is Wales' largest public sector trade union with over 90,000 members working across Welsh public services.

UNISON Cymru/Wales health care members are from all non-medical occupational groups including: nurses and health care assistants; midwives; health visitors; occupational therapists; administrative, finance and HR staff; ambulance staff including paramedics, technicians, control room and maintenance staff, therapy and healthcare science staff; estates and housekeeping staff; technicians and maintenance staff; commissioning staff; allied health professionals; scientific staff; healthcare managers.

UNISON Cymru/Wales social care members include social workers; occupational therapists and social care workers working across residential, non-residential and domiciliary care services. Our members undertake roles in early years and childcare; mental healthcare; care for older people; disabled people's care; caring for people with learning disabilities.

There is absolute consensus amongst our local government and health sector members that integration is the way to go in order to improve services. This is especially so in light of the current economic climate. We understand that this process is about doing more with what we have got and achieving a more effective service which will help patient and employees alike

However, we believe that integration cannot work unless it has the backing of all employees, with provision for everyone to be involved in the service design and working together to realise the end goal.

UNISON Cymru/Wales therefore believes that the integration of Health and Social Care in Wales should be based on five common principles:

- Collaboration and co-location and not structural integration
- Health and Local Government pooling resources
- No further privatisation
- Stronger role clarification for the professionals delivering the integrated service
- Good practice harmonisation of policies and culture

To positively move forward this principled approach to the integration of Health and Social Care, at scale and pace, UNISON Cymru Wales has commissioned this report: to produce up to date and focused analysis on what is happening in Wales; to increase the understanding of the issues amongst our activists and to inform and influence policy makers to ensure the potential of integration is fully realised.

Margaret Thomas
Regional Secretary

UNISON Cymru/Wales

1. INTRODUCTION AND APPROACH

The Welsh Institute for Health and Social Care (WIHSC), University of South Wales was commissioned by UNISON Cymru Wales to understand the experiences of those who have been working on integrated models of health and social care. The project was designed to establish what is happening in respect of achieving the integration of health and social care, identify interesting examples of approaches to integration in Wales, and analyse the work undertaken to achieve integration of services for older people in three case study locations. WIHSC has produced this report for UNISON which we trust will enable a better understanding of integration amongst UNISON activists, and inform and influence policy makers in what needs to happen to accelerate the implementation of integration in Wales.

1.1 METHOD

In order to achieve this, there were two key phases which ran from January-May 2018:

DESK RESEARCH

Ahead of the case study visits, our desk research laid much of the groundwork for the substantive research phase that followed, and comprised two principal elements: a brief literature review (the results of which are integrated in the 'Conclusions' chapter) and a desk research exercise to identify current examples of integration across Wales. The desk research was conducted to find projects, reports and publications relating to examples of integrated working in practice at local, national and international levels. Whilst other UK countries and international examples of integrated working were of interest, the primary focus of the search was to identify existing project examples in Wales. To manage the volume of information, older projects, dated circa 2009 or earlier, were excluded.

In addition to the online search, the senior project team also identified several recently published documents that were studied with the aim of finding additional project examples. Through the online search and document reviews, numerous key project examples – which range in scale and size – emerged which were relevant to the brief. A compendium of 143 Welsh examples is included in Appendix I, and it should be noted is not exhaustive – this was a time-limited exercise.

CASE STUDY RESEARCH

Building on the desk research phase, we undertook detailed research into three integration projects. The three potential case studies were identified through a combination of UNISON's networks and those of the research team. The case studies that were chosen were as follows:

1. Monmouthshire (Gwent) – examining the strategic context, workforce integration, and the operation of integrated teams in Monnow Vale;
2. Bridgend (Western Bay) – exploring a number of work streams that have been focused on continually improving integrated community services for older people; and
3. Ynys Môn (North Wales) – investigating the integrated provision of enhanced dementia EMI residential care.

The case studies involved the team spending time in each of the localities interviewing a range of key people – from the frontline workforce to strategic leaders and those in-between – to examine the different approaches being adopted in the three chosen examples on:

- the implications the projects have had for the workforce;
- the mechanism for the trade unions to engage with the process of determining and developing the integrated service;
- how Welsh Government is perceived to have impacted on achieving integration in Wales;
- the role of structures, including governance arrangements involving the Regional Partnership Boards (RPBs) and Public Service Boards (PSBs) in assisting implementation;
- the role of local organisational leaders in this process;
- whether and how the 'fragmentation' of social care has impacted on the ability to achieve integration and vice versa;
- the impact of additional financing and resources in enabling or hindering the integration practice; and
- the factors, overall, which have assisted implementing integration at greater scale and pace;

The findings from the case studies were shared with the key informants to sense check the accuracy of the outcomes of the research.

1.2 REPORT STRUCTURE

The next chapter of the report provides an important context for the study – in terms of both policy and legislation. Following that, we provide an analysis of the findings from the three case studies. The last chapter locates our findings against what we know about integration from the literature, and in the light of the recently published Parliamentary review into health and care services. We trust that this report will not only support better understanding of integration amongst UNISON activists but also influence policy makers in terms of what needs to happen to accelerate its implementation.

2. CONTEXT

This chapter provides information about both the legislative and policy underpinning our study.

2.1 THE CONTEXT FOR THIS RESEARCH - UNDERSTANDING INTEGRATION, INTEGRATED CARE AND COLLABORATION

It is important to create a solid basis of understanding about integration and collaboration in the context of health and social care to assist more detailed research and evaluation of specific initiatives and attempt to achieve an integrated approach. In doing so, we have reflected upon policy developments in integrated care, explored conceptual understandings of integration and collaboration, and described some of the tools available to convert the integrated approach from one of theory to reality.

Despite numerous commentaries, strategies and government statements, it is acknowledged that the term "integration" still has many definitions in the context of care and support and is, therefore, open to interpretation. Integrated care is not a new concept and is founded on the long standing and more easily understood principle and practice of working together. There is already a good track record of integrated services in Wales, developed locally and regionally, and illustrated most vividly by the regional initiatives supported by the Integrated Care Fund. Our review of the literature highlights numerous examples of integrated care being practised in Wales which suggests an increasing understanding of its importance and relevance. However, the Social Services and Well-being (Wales) Act 2014 has brought a fresh impetus to collaborative working through its statutory obligations for co-operation and any evaluation of attempts at integration must now be against a test of embeddedness and sustainability rather than short term gain.

Having a mutual understanding of integration amongst partners, and agreed by both linear and cross sector governing bodies, such as the regional partnership boards, is necessary to avoid confusion or disagreement in respect of implementing both the requirements and spirit of the Act. Previously published Statements of Intent and strategic plans may already include an agreed understanding, and ideally an agreed definition, across each region but priority must now be given to embracing integrated care as an essential component of the planning and delivery of health and social care services.

2.2 INTEGRATION IN WALES

The report of the Parliamentary Review of Health and Social Care in Wales[1] makes numerous references to the need to integrate across a range of different subjects. These include integrating strategic approaches, information, advice and support, public consultation and engagement mechanisms, career paths for the health and social care workforce, new models of health and social

[1] Parliamentary Review of Health and Social Care in Wales (2018) *Seamless, community-focused health, social care and well-being for older people in Wales: Key Principles and Features* – accessible from: https://beta.gov.wales/sites/default/files/publications/2018-01/Seamless%20Care%20Principles%20and%20Features.pdf

care, organisation accountability, reporting arrangements and infrastructure, systems and resources. Significantly, the report uses "integrate" as an active function, and only rarely refers to "integration". This is helpful in respect of avoiding pitfalls of definition, avoiding confusion of means and ends, and seeing the need to integrate as a positive and sensible activity.

Of particular relevance to this research project is that the report refers to the need for "a close harmonisation between the NHS and social care at a national level to ensure that the blend of incentives is effective to develop new models of integrated health and social care, especially where social care is provided by a large number of non-public organisations in many different settings." The report locates the benefits of integrating clearly in the context of achieving a "seamless" approach to meeting need and providing services. Significantly, documentation produced by the Review Team to support the report refers to the integrated approaches in Monmouthshire and Bridgend as being amongst those considered to be most aligned with the principles outlined in recommendation 3 of the final report of the review, "Bold New Models of Seamless Care – national principles, local delivery."[2]

Experience and research have shown that there are many obstacles to achieving successful collaboration and integration. Frequently the means do indeed become confused with the ends and actions taken to enhance integrated working become proxies for having achieved the goal of people experiencing care and support that is seamless. So, for example, creating a pooled budget, co-locating teams from different agencies and having joint appointments are all recognised enablers to achieving integration. However, they may still not achieve the ultimate goal of the truly seamless response to meeting need. Similarly, some might suggest that integration can only be achieved via significant organisational change and restructure, yet this too is a means rather than an end in itself regardless of opinions about its veracity. Integration must be considered at both strategic and operational levels if its value and relevance is to be fully appreciated and understood.

Notwithstanding any criticism of the apparent concentration on means rather than ends in some cases where integration has been difficult to achieve, it is important to recognise success in triggering some of those mechanisms to support it in practice. They also help to clarify what could comprise a fully integrated approach. The following, included in the toolkit prepared by the Social Services Improvement Agency[3] to support the production of population assessments required by the 2014 Act, might describe such a position:

- An approach to the planning, organisation and delivery of health and social care services:
- Where partners work together on a common cause and are prepared to share sovereignty;
- Where integration is commonly understood and leadership to deliver integrated solutions is shared;

[2] Parliamentary Review of Health and Social Care in Wales (2018) *A Revolution from Within: transforming health and care in Wales* – accessible from: https://beta.gov.wales/sites/default/files/publications/2018-01/Review-health-social-care-report-final.pdf

[3] Social Services Improvement Agency (2016) *Population Assessment Toolkit* – accessible from: https://socialcare.wales/research-and-data/research-on-care-finder/population-assessment-toolkit?record-language-choice=en-cy

- Where integrated care is built from the bottom up as well as the top down;
- Where professionals are tolerant of each other's business pressures and the complexities of the challenges therein;
- Where resources are pooled, teams are co-located, and commissioning undertaken jointly;
- Where the workforce is used flexibly and effectively and is open to innovations in skills mix and staff substitution;
- Where information is shared widely and openly;
- Where there is shared governance and shared accountability;
- Where assessments of need and care pathways are developed jointly with the aim of maximising joint working for the benefit of the individual.

We will return to the extent to which these featured in our case studies as part of our conclusions.

Whilst addressing all the complexities of achieving integrated care may prove elusive, reinforcing the importance of eliminating potential misunderstandings about its meanings remains fundamentally important to its pursuit. It is sometimes easier to understand what integration means when it is considered from the viewpoint of the person receiving a service. Welsh Government's Framework for Delivering Integrated Health and Care for Older People with Complex Needs[4] makes some useful comments in this regard. It suggests that for those people needing care and support integration should mean that: "My care is planned by me with people working together to understand me, my family, and carer(s), giving me control, and bringing together services to achieve the outcomes important to me."

It is effectively the opposite of receiving a fragmented series of interventions from different agencies, who often appear not to be communicating with each other, that can lead to confusion, disruption and poor outcomes.

Guidance on the Integrated (formerly Intermediate) Care Fund[5] has also helped to assist our understanding of integration when it referred to the fund aiming to encourage integrated working with schemes clearly demonstrating the role and contribution of all relevant partners within the region. It also referred to proposals demonstrating effective local delivery arrangements, based on discussion with Local Authority Housing and Social Services Departments, Local Health Boards, Registered Social Landlords and other Third Sector organisations. The guidance promoted the need for effective delivery arrangements to utilise, and strengthen further, wherever possible, the partnerships that already exist as well as creating new ones.

Integrated care applies to people of all ages and there is no limit to the agencies involved in achieving an integrated approach to care and support. Plans should reflect this by not being confined solely to care involving social services and health. The contributions of the third and independent sectors,

[4] Welsh Government (2014) *A Framework for Delivering Integrated Health and Social Care for Older People with Complex Needs* – accessible from: https://gov.wales/docs/dhss/publications/140319integrationen.pdf

[5] Welsh Government (2017) Intermediate Care Fund Guidance 2016-17 – accessible from: https://gov.wales/docs/dhss/publications/170518icf-guidanceen.pdf

housing and education, for example, should feature in the joint area plans now required by the 2014 Act as should co-productive work with carers and others.

Finally, it should be noted that integration can take place locally, regionally and sub-regionally. The population assessment toolkit suggested that, in the spirit of recognising that there is no best way of achieving integration, the value of attaining it in part rather than no integration at all must be recognised. Hopefully, local and sub-regional initiatives can then be used to develop approaches across the whole region.

Integrated care, therefore, is now clearly embedded in Welsh Government's health and social care policy and legislation and the current direction of travel is likely to be reinforced by the Government's response to the Parliamentary Review. If integrated working is to become the default position in health and social care in Wales, understanding about its meaning and implications must be universal and not remain the province of any particular interested party. This means the need to integrate must be seen across the whole spectrum from organisational leaders to users of services and carers. Importantly, integration of health and social care must be understood within the context of wider considerations of why individuals and organisations collaborate and how collaboration per se is located in Welsh public policy.

2.3 INTEGRATION AS PART OF A COLLABORATIVE APPROACH

Collaboration is a complex field of study that warrants deeper understanding by those responsible for creating and implementing public policy if it is to fulfil its central position in respect of the delivery of public services in Wales. Despite growing experience with collaborative initiatives, they still remain vulnerable to political vagaries, economic shifts, institutionalised norms and ecological barriers. This leaves them unable to create and command the consequential and constitutive value needed to be sustainable unless corrective and compensatory action is taken. Research suggests there is a suite of characteristics by which the efficacy of collaboration as a credible public policy can be assessed, short of evaluating its outcomes.

There is evidence that collaborations are not consistently defined, can be formal and informal, and take on a variety of different forms and designs. Collaborations can arise out of different motivations and reasons, some of which involve theories about the dependency and exchange of resources and others rooted more in rational-altruistic grounds. They can also produce different outcomes ranging from mutual learning to real gains in efficiency and effectiveness and they contain contradictory elements that can include competition and conflict working against and within the collaborative endeavour.

Collaborations display the practical implementation of elements of organisational, institutional, network and agency theories and are frequently inextricably considered as an instrument of governance. A wide range of factors impact on their chances of success which change as they move through a life cycle of different phases. This suggests that as partnerships evolve, relationships change and need to be refreshed and reinforced. The enthusiasm, for example, in the formative years of a partnership may wither as the practical realties of the implementation stage become clearer.

Collaborative working can occur vertically and horizontally in an intra, inter and cross-sector context reflecting both hierarchical and market forces as means of implementing public policy. Within collaborative activity there are strong socially interactive forces at play, such as power and trust, illustrating a dependence on certain behaviours to fulfil the collaborative objectives. Fundamentally, collaborations are dependent on the contribution of people as networkers, leaders and stakeholders displaying a wide range of skills and competencies.

All these characteristics are invaluable in adding to knowledge and furthering our understanding of collaborations and collaborative behaviour but do not readily lead to a straightforward typology of collaborations. For example, we know that mutually beneficial motives can disguise residual elements of conflict and competition. Similarly, the pursuit of a neat organisational design for the collaborative form has to take account of numerous informal networking aspects, some of which are not immediately evident. The issue of governance can become inextricably linked with the collaborative initiative and it is often difficult to precisely identify the shared objective of a strategy.

2.4 AN ASSESSMENT OF COLLABORATION TO DATE

So, if it is possible to offer characteristics of collaboration but not possible to fully typify it, how can we identify the common features needed to improve the chances of collaborative success?

Looking at the national perspective, one argument which emerges is that we should celebrate any lack of conformity, and resist criticism of the diversity of approach to collaboration in Wales, instead seeing it as a necessity given the culture of Welsh public policy. This typifies a liberal approach where, it could be argued that by enabling local individual initiative to determine what drives the reasons for collaborating and the form it should take, the collaborative experience becomes richer and more sustainable and relatively free from state control. To a large extent, this has been the approach taken to date in Wales, within a framework of government policy favouring collaboration as an alternative to the competitive approaches of the market. However, not only is such a choice not as clear as first appears but also the inclusion of legislatively based imperatives for public agencies to cooperate in two significant pieces of legislation, namely the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015, has signalled that the voluntary approach is not felt to have produced the scale and pace felt necessary by government. Accompanying statutory guidance on partnerships makes provision for national and regional approaches to functions such as adoption services, safeguarding and economic well-being. The pooling of funds across health and social care is made mandatory in specific functions and is proving to be a complex and difficult task. On a more positive note, public agencies could point to evidence that progress was already being made on a number of collaborative fronts and in some instances, the Acts have helped by giving authority to what they were doing already.

In the case of collaboration amongst local authorities, some may argue that despite including reserve powers to direct, government policy has been compromised by the need to appease local discretion, consistent with the central/local partnership culture which central and local government have sought to foster. A quick review of government initiatives since 2003 illustrates the different attempts by central government to create the right balance of local autonomy and shared sovereignty in public services. We have seen the creation and subsequent dismantling of local health boards co-terminous

with local authorities, the publication of Making the Connections as confirmation of the collaboration strategy, the Beecham (2006)[6] and Williams (2014)[7] reports on public services, the creation and abolition of local service boards, the creation of public service boards, the regional footprints, the advent and demise of community strategies and single integrated plans, the Compact for Change, the threat of a collaboration legislative measure, legislation to support collaboration, and a Local Government Act (2015) paving the way for reorganisation.

It is against this background of policy development that efforts to integrate health and social care have needed to progress and the debate remains as to whether overall government policy is clear and consistent enough to ensure more collaborative effort.

This evidence suggests fulfilment of the Welsh Government policy agenda on collaboration appears to be at least uncertain. The WIHSC overview of the first round of annual reports by statutory Directors of Social Services, "Achievements & Challenges[8], undertaken on behalf of the Social Services Improvement Agency, showed progress in partnership arrangements by Welsh local authorities in a wide range of service areas but possibly not in a manner which represented a full strategic approach, not at that time consistently across the regions, and frequently presented as much as a challenge as an achievement. The SSIA report on collaboration in social services in Wales (2013)[9] reflected failed attempts by four authorities to deliver their declared goals of achieving extensive integrated services across their geographical boundaries. Therefore, even when counterbalanced by some success stories, there appears to still be some distance between strategic intent and successful implementation of this key central government policy, certainly in respect of significant collaboration at the organisational level.

However, the alternative to voluntary collaboration, namely a hierarchical, mandated approach, whereby government prescribes the routes to be followed, seems equally unattractive because it belies the complexity that has been identified. The Williams Report (2014) made clear that something had to change for collaboration to become more consistent and effective. In this context, grant funding and programme bending towards regions in health and social care, at the same time creating local authority based public service boards, has, paradoxically, embedded the collaborative culture and confused the policy. An uneven patchwork of local regional governance arrangements for different functions has potentially exacerbated the problem.

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[6] Beecham, J. (2006) *Beyond Boundaries: Citizen Centred Local Services for Wales.* Welsh Assembly Government – accessible from: http://www.wales.nhs.uk/sitesplus/documents/829/WAG%20-%20Beyond%20Boundaries%20%28Beecham%20Review%29%202006.PDF

[7] Williams, P. (2014) *Commission on Public Service Governance and Delivery in Wales* ISBN 978 1 4734 0837 1 – accessible from: https://gov.wales/topics/improvingservices/public-service-governance-and-delivery/report/?lang=en

[8] Social Services Improvement Agency (2011) *Achievements and Challenges: A picture of social care provision in council areas across Wales in 2009/10, drawn from the reports of the 22 Statutory Directors for Social Services* – accessible from: https://socialcare.wales/research-and-data/research-on-care-finder/achievements-and-challenges-a-picture-of-social-care-provision-in-council-areas-across-wales-in-2009-10-drawn-from-the-reports-of-the-22-statutory-directors-of-social-services

[9] Social Services Improvement Agency (2013) *Collaboration in Social Services - A User Guide to Help Local Authorities Address Social Services Collaboration and Achieve Good Governance in a Collaborative Context* Cardiff: Wales.

In the context of health and social care, significant additional funding via the Integrated Care Fund, with its emphasis on improving care co-ordination, has facilitated numerous initiatives to integrate care and the new regional partnership boards have been established to produce a real shift in the scale and pace of collaborative working. However, the latter, whilst demonstrating a promising start, lack many of the tools available to more linear governing bodies, e.g. staff and other resources and direct decision-making authority, to make this happen and their ability to enforce collective decisions on anything less than unanimous agreement remains untested. The extent to which they can grow into a major contributor to the collaboration landscape also, therefore, remains uncertain.

3. CASE STUDY - MONMOUTHSHIRE

3.1 DESCRIPTION OF THE INTEGRATED MODEL IN MONMOUTHSHIRE

The model of integrated health and social care is locality based with three health and social care hubs. Services are delivered to the Monmouthshire population under single management agreements. Each hub has one Integrated Services Manager responsible for the delivery of services across health and social care. The teams are made up of occupational therapists, physiotherapists, community nurses, chronic condition nurses, social workers, direct care staff and relevant support staff. Staff are employed by either the Aneurin Bevan Health Board or Monmouthshire County Council. The third sector sources volunteers, who are managed by the hubs.

The delivery model varies in each hub depending on previous service developments, for example one hub has rehabilitation beds and one hub has an in-patient ward.

Prior to the development of the model; services were managed separately under different management structures, referrals, service delivery and performance was managed independently and referrals were passed between different service areas each with their own criteria etc. In this model “a referral” comes into the team and “the team” provides whatever support / intervention is required - there is no requirement for referrals to be made between team members.

The model covers the whole of Monmouthshire (population 92,336) for people aged 18 plus. Older adult and mental health are not included as there are other arrangements in place. Direct care has been included within this model since 2017.

The three hubs are at Chepstow, Mardy Park (Abergavenny) and Monnow Vale (Monmouth). The focus of this case study is the Monnow Vale hub.

3.2 MONNOW VALE

Monnow Vale provides a range of services for people who live in Monmouth, Raglan, Usk and outlying areas, although people from other areas can access the service. It consists of an inpatient ward, day services, specialist clinics, a café, space for families to stay over, a specially designed room suitable for reminiscing (dementia), an intermediate care team and a long term support team. The well-established team at Monnow Vale is led by an Integrated Services Manager who is also the professional lead for Occupational Therapy. She is a Health Board employee, reporting to a line manager who is a Head of Service at Monmouthshire County Council. Her team is made up of Auxiliary and Reablement Nurses, District Nurses, Chronic Conditions Nurses, Physiotherapists, Occupational Therapists , home care workers, administrators and facilities staff.

The hub provides services previously based at Monmouth Hospital, Overmonnow Day Hospital, Dixton Road Clinic, Social Care and Community Nursing Teams and Day Services. It was developed in partnership with Monmouthshire County Council, local Voluntary Organisations, Gwent Healthcare NHS Trust and Monmouthshire Local Health Board. A mini hub is being developed in Usk to be opened in May/ June 2018.

There is one assessment for people who need care and support, and staff share the bespoke database (designed by the workers to minimise and make recording as close to practice as possible)and work from the single assessment. Staff indicated colocation enables quick mobilisation of resources to respond to identified needs. Unnecessary bureaucracy is eliminated and the focus is on using skills to support well-being outcomes for people. Some key messages about the way of working in the area covered by Monnow Vale were:

- Staff are freed up to focus on what matters to people who need care and support.
- Their skills and expertise are recognised, used and valued.
- They are "part of something bigger".
- The importance of sharing values.

3.3 ORGANISATIONAL LEADERSHIP OF THOSE DELIVERING THE INTEGRATED ACTIVITY

This has been identified as crucial to effective integration at Monnow Vale and Monmouthshire more widely. There is said to be leadership at all levels of the integrated approach that influences the culture and supports the integration agenda. A shared corporate culture has been identified. Clarity about aims, and creative thinking about "how we can make this work" underpins the integrated approach. There is an open door approach into senior level discussions.

Changes in senior management and structures have been identified as a compounding factor, with a locality structure from a health perspective being considered more enabling to the integrated approach. A key success factor is said to develop relationships based on trust and respect, which is considered easier to do in a more local setting.

Robust governance and operational arrangements are thought to be essential to integrated services with clear understanding of responsibilities. Each of the Integrated Service Managers has the budgets from across the organisations but the requirements for accountability remain the same. Managers work across two organisational services with regard to HR, finance, policies / procedures etc.

3.4 RELATIONSHIPS BETWEEN "KEY" DECISION MAKERS

The integration agenda in Monmouthshire leading to the development of the hub approach and Monnow Vale has been developed over many years and has been described as an "ongoing journey". There are a set of long standing positive relationships of mutual respect and trust between all partners– statutory, trade unions, Third Sector and independent sector around integration. The importance of and honest and strong relationship, equality of partners and a willingness to both challenge and collaborate was highlighted as fundamental to integration success.

The potential for building relationships in a locality structure as opposed to a more centralised structure was identified. Getting the right people around the table who had a willingness to engage, and preparedness to make decisions is also seen as crucial to make integration happen.

3.5 ROLE OF THE PUBLIC SECTOR WORKFORCE

Within the area covered by the Monnow Vale hub, there is a set of shared values and behaviours which underpin the integrated approach. The staff approach to integration can be seen as impacting positively on the success of the integration agenda. There are clear expectations of behaviours and these are articulated in job descriptions and in the recruitment process. Employees from the statutory sector, the third sector and the trade union described this shared and clearly understood approach. "What matters" to people who need care and support is at the centre and everything hinges on that. Front line staff described this approach, and said that this was a key reason for wanting to work at Monnow Vale. They said that they felt empowered to take action and to get things done, working seamlessly.

People can be recruited by either the Health Board or the County Council into roles and it is possible, on a case by case basis, to choose either employer. The indications are that they stay with their current employers, perhaps for reasons of familiarity or pensions. One example provided was of a post which was advertised by the Council, and a Health Board employee was successful – they were able to choose to stay as a Health Board employee. While job descriptions are aligned, there has been no alignment of terms and conditions between Health Board and Council staff.

Staff are co-located and work both within the hub and in the wider community. There are staff doing the same job who are employed by different organisations e.g. Occupational Therapists (OTs) and Support Workers.

Staff said that an important reason for working in Monnow Vale was the fact that their work is completely people centred. They have authority or "permission" to act, and a mantra is "We trust the judgement of front line staff". They felt that by working in an integrated way they were able to reduce bureaucracy and ensure that people had the right support at the right time.

People reflected on the continuity of staffing. People come to work and stay in Monmouthshire because they like the integrated approach. They attract and retain practitioners – social workers, OTs, OT support, physios. There are challenges for recruiting managers and a recent team manager recruitment failed to appoint. There are high quality, experienced practitioners but they do not all indicate that they want to step into management. Lack of financial incentive due to pay levels was also referenced.

The "Raglan" project[10] (initially piloted in Raglan, now covering all of Monmouthshire), came about 4 years ago through discussions between care at home staff and management. Staff raised issues about their jobs, and the impact for people who needed care and support, which were explored and the direct response was the "Raglan" project. This involves council led Care at Home staff (about 140 people). Key influencers for the change were the staff, people who need care and support and carers themselves, alongside responsive leadership.

A pilot followed by a staged roll out was conducted, with discussions taking place with trade unions. The approach at that time was about delivering on care plans with specific tasks at specific times. This

[10] http://www.monmouthshire.gov.uk/app/uploads/sites/11/2014/05/6a-Select-Committe-Report-The-Raglan-Domiciliary-Care-Model.-Appendix-1-Evaluation-Short-Summary.pdf

has moved to supporting people to achieve what they wish for their personal outcomes. Care at home staff are fully involved as partners in the approach, which is to provide support for people with dementia in their own homes. The terms and conditions for care at home staff have changed from zero hours contracts to salaries with contracts for the majority of 35 hours a week. This provides stability and consistency as well as flexibility and a more fulfilling role for home care workers.

There is a reconciliation by payroll every 6 months; however, if staff have worked less they do not get money taken away. It is the responsibility of their managers to make sure that overall, the hours balance. Staff have received appropriate training e.g. emotional intelligence, dementia training to support them in changes to the way they work.

Staff work in set teams of five or six. The team is responsible for covering absences and ensuring that the service user has their needs and wishes met. In terms of what it means for people who need care and support, they are in the driving seat. If they want to do something in particular, go for an appointment, go shopping, they are supported by the home carer to do that. This does require a different set of competencies and person specifications, and there has been a considerable amount of work to do in training and supporting staff through the change, and ongoing support and development. The change in emphasis has been received positively by the majority of staff, however, the challenges in changes to ways of working are recognised. The focus is now on relationship-based care, giving staff autonomy and "permission" to develop relationships with the people they support.

There have been no negative issues on this change flagged to UNISON.

3.6 ROLE OF ADDITIONAL FINANCE AND RESOURCES

The Integrated Care Fund (ICF) and Delivering Transformation Grant (DTG) funding were identified as catalysts for furthering the integration agenda. However, the uncertainty of ongoing ICF funding is a real challenge, and time limited funding challenges sustainability. To start a project which was successful and provided people with a positive experience and good outcomes, then to have to end it with no replacement due to the inability to source additional further funding was potentially unethical. Looking at the long game is important in Monmouthshire and sustainability is key to that.

3.7 ENGAGEMENT OF TRADE UNIONS

There is a long standing history of positive relationships between UNISON and the council, health board and third sector around integration. UNISON was fully involved in the initial work over 7 years ago. Whilst having some initial reservations, the integrated approach had been very positive in what it achieved for people who need care and support and for staff. While noting the "two tier" system with different pay and terms and conditions, UNISON members have not raised this as an immediate priority issue to tackle. There is said to be an honest and open dialogue between UNISON and the statutory partners.

3.8 ROLE OF WELSH GOVERNMENT

The SSWBA and associated statutory guidance clarifies that care and support should be integrated around people to support them to secure personal well-being outcomes. The Act provides for new statutory partnerships between local authorities and health boards to drive integration, innovation

and service change. Additional funding in the form of the Delivering Transformation Grant and Integrated Care Fund (ICF) has underpinned this.

Perspectives on the impact of Welsh Government on the integration agenda in Monmouthshire, and specifically the Monnow Vale hub were gathered. The aspirations of the Act were supported and the overall view was that the journey to integration had preceded the Act, but that the Act gave authority to the local agenda.

The requirement for many plans by different parts of the sector is seen to have a negative impact on integration. Different organisations are required to produce documents, having an impact on resources and leading to a fragmented approach. A shared plan and approach would be a real bonus and reduce complexity and waste.

The importance of engaging regionally with the RPB was raised in relation to grant funding such as DTG and ICF.

3.9 ROLE OF "STRUCTURES" – INCLUDING THE RPBs AND PSBs

Monmouthshire is a member of the Gwent Regional Partnership Board. The Partnership covers the area of the Aneurin Bevan Health Board. The Gwent Regional Partnership Board (RPB) was formed directly as a result of the SSWBA (Part 9 of the Act). A considerable amount of development work has taken place to promote these arrangements. The terms of reference for partnerships have been reviewed and revised for consistency and to make clear the reporting accountability to RPB. The terms of reference review has also been extended to the Greater Gwent Workforce Development Board and to the Provider Forum and Citizen Panel. Partnerships are taking a consistent approach, to meet on (at least) quarterly basis, and to develop a high level work plan (linked to the regional Area Plan) in order to track work streams and to be able to report to the RPB.

Within Monmouthshire, there has been an Integrated Services Partnership Board (ISPB) for many years, on the understanding that it is essential to have partners around the table. An issue is the decision making authority is not the same for each member of the Board.

There is not a clear picture on the role and relevance of the RPBs and PSBs from the Monnow Vale/ Monmouthshire perspective. From the regional perspective, a considerable amount of work is being done to ensure that the regional structures are supportive and relevant.

3.10 "FRAGMENTATION" OF SOCIAL CARE

Although Monmouthshire has a lower level than the rest of the region in respect of the outsourcing of home care workers, there are independent sector employees working in the field. Monmouthshire figures at end of 2017 were 568 people (76%) supported by commissioned independent sector providers and 153 people supported by in house home care (24%). Monmouthshire use ten different independent home care providers for this.

There are different pay scales, terms and conditions for health board and council staff. There is a healthy debate between health and the council about how they can work better and how resources are contributed. Processes for funding staff are complex. They involve charging and recharging but

this is done via set Section 33 agreements. There will be costs associated with having to undertake this work. Process issues are managed so no patient or staff member is affected, or even aware.

There are multiple employers to deal with, different policies and pay scales. Team managers may have a large team of people from different organisations with different terms and conditions. This was not an issue and "People get on with it". The motivating factor was a shared purpose and the standard expectation is everyone will work together, regardless of salary, and terms and conditions. There are people doing the same jobs for different rates of pay that are all galvanised around their purpose and share common operating principles.

The importance of valuing independent sector home care workers was raised. A number of agencies operate in Monmouthshire. One innovative plan to encourage an integrated approach with private sector home carers revolves around the new mini-hub in Usk. The intention is to make it a place which welcomes people from the independent sector. Care staff will be welcome there for information advice and support, to tell the staff based there if they identify any issues and concerns to facilitate a seamless service as what it is in reality is a shared caseload between LA/HB and the independent sector. This flows from a piece of work called "Turning the World Upside Down"[11] which is focused on developing care plans and the delivery of patch based person centred support – with a significant emphasis on the shift from transactional to relationship based care. Five providers are currently working on this Monmouthshire-wide project.

There is close working with the Third sector, which takes on the role of the recruitment and co-ordination of volunteers both in the hubs/wards and in the community. They are a significant element of the multi-disciplinary teams; attending weekly MDTs to identify people/carers who may benefit from their input.

[11] https://democracy.monmouthshire.gov.uk/documents/s13143/Turning%20the%20World%20Around.pdf

4. CASE STUDY - BRIDGEND

4.1 DESCRIPTION OF THE INTEGRATED MODEL IN BRIDGEND

The integrated services for older and disabled people in Bridgend are part of an overall approach to working together to integrate and improve the planning and delivery of community services for frail and disabled people. All services are included other than those for people with learning disabilities and mental health and substance misuse The commitment by the Western Bay region, begun in 2013 through its Health and Social Care Programme, is a whole systems approach to addressing the challenges of the issues presented by an ageing population. Whilst being an important part of that development, the Bridgend model is more extensive than any other part of Western Bay as it integrates core services as well as those in intermediate care.

The aim of the programme is to transform services so that citizens (typified by someone whom they call Mrs Jones) experience a well-coordinated and planned approach to community health and social care services. The focus of the programme is to develop pathways of care that promote independence and wellbeing, avoid duplication, unnecessary admission nursing / residential care settings, and/or to hospital, as well as supporting early discharge and independence in the community. The ambition is that these services support independence, health and wellbeing, and focus on reducing dependency and minimising risk to independence.

Integrated community services for frail and disabled people are now well established and this case study concentrates on two elements:

- Community Resource Team Services (CRT), which includes an acute clinical team, reablement, telecare and mobile response. This is a regional approach to intermediate care and subject to a Section 33 with the Health Board. The CRT also includes a common access point as part of an intrinsic part of avoiding duplication.
- Three Integrated Community Network Teams comprising social work, district nursing and therapies.

COMMUNITY RESOURCE TEAM

The CRT is the amalgamation of intermediate care services in Bridgend into a single service. Referrals to the service are made through a single point of contact, the Common Access Point, which is staffed by experienced social work assistants with access to a multi-disciplinary team. This streamlines the process of referral ensuring interventions are delivered in the most appropriate way, therefore avoiding duplication of referrals.

The CRT works within a person centred, proactive care coordinated model, with an emphasis on the benefits of working as a multi-disciplinary service within a multi-agency framework. Programmes of enabling and re-enabling support are assessed, led and developed by the appropriate professional thus ensuring that care is assessed professionally and delivered appropriately. The Community Resource Team therefore, offers maximum meaningful independence at home or in Bridgend's Reablement Unit.

Within the CRT in Bridgend, there are integrated management posts which operate single line management. Senior management posts consist of a senior nurse, senior OT and senior social worker and there is access to senior roles of allied health professionals within core services, which facilitates lines of escalation for all roles within the CRT. This supports good governance and oversight.

Intermediate Tier services in Bridgend are underpinned by a Section 33 pooled fund agreement between the local authority and the health board. Investment in the services is significant on an annual basis from both partners from core funds and is enhanced by Intermediate Care Fund(UCF) monies which has created an opportunity to accelerate service redesign and develop new ways of working.

INTEGRATED COMMUNITY NETWORK CLUSTER TEAMS

The creation of networks was designed to transform traditional models of service, where social services formerly provided teams for older and physically disabled people, and community health services separately delivered district nursing through numerous associated access points, to having integrated teams comprising social workers, occupational therapists and district nurses, all managed under single integrated management based on the footprints of the community network clusters.

For those who still need managed care and support, three integrated community network cluster teams have been established, with professionally led fully integrated management. These teams comprise social work, district nursing, and community occupational therapy. There are three integrated community network managers who individually have professional leadership roles for either community nursing or social work, and governance issues.

The aim of the transformation of services is that citizens experience well-coordinated and planned approaches to community health and social care. Some of the key features of the networks are:

- **Anticipatory Care Planning**

  This model is based on learning from the Torbay Care Trust, and the extensive work of the Scottish NHS, on anticipatory care planning. This is a multidisciplinary GP practice based approach to developing co-produced anticipatory and contingency plans with individuals, to avoid personal and family crisis, and can prevent unnecessary admission to hospital or long-term care. These enable all professionals to have access to individual agreed plans of support; the plans are shared with primary care and community services and out of hours services, in order to support better outcomes for individuals.

- **The Community Independence and Wellbeing Team (CIWT)**

  This is a multidisciplinary countywide integrated health and social care team that works with adults who have complex and long-term life limiting illness, chronic progressive or improving health conditions, and with people who have the sudden onset of impairments as a consequence of trauma. The team works to support people to retain and regain maximum independence and well-being and to develop the ability to manage their disability or illness.

  The CIWT Team service is able to provide a multidisciplinary response to individuals, which is person centred, recognising that people with complex long-term conditions can have fluctuating needs, and is able to respond proportionately and prudently to individual situations.

The team works to a social model of disability, which positively promotes choice, control, dignity, equity, opportunity and coproduction as well as community participation.

Many of the people using this service are of working age and since the implementation of the service, reliance on traditional residential nursing respite and placements has all but stopped, as more flexible person centred approaches to support and short breaks have been developed for individuals. The team has enabled people in tertiary services recovering from disability as the result of trauma, to be rehabilitated at home, and enabled their discharge from regional hospitals to be expedited.

4.2 ORGANISATIONAL LEADERSHIP OF THOSE DELIVERING THE INTEGRATED ACTIVITY

The progress made towards integrated care is largely attributed to strong, clear and inclusive leadership, driven by the commitment of senior managers but consistently cognisant of the need to gain the support of staff. The emphasis has been on not allowing debates about organisational structures to impede the integration and delivery of services and this has been achieved by working with staff to formulate a shared vision of how integrated services benefit people. A fictitious user of services, “Mrs Jones”, helps bring reality to this.

There are integrated posts from senior management level down and Section 33 arrangements put in place where prudent to do so both locally and regionally. Memoranda of understanding about service specifications and objectives and a statement of intent confirm intentions and assist in retaining a focus on the shared vision. Strategies are formulated jointly and there is a common understanding that resources are finite and agencies have an absolute public duty to spend them prudently and wisely.

A Leadership Group ensures ongoing senior level commitment and a key success factor is said to be the willingness to be courageous enough to adjust models through learning about their effectiveness in practice. This involves continued engagement with, and learning from, frontline staff.

4.3 RELATIONSHIPS BETWEEN “KEY” DECISION MAKERS

Bridgend has a long history of partnership working between health and social services and mutual trust has developed to a point which enabled the changes to be made. The current arrangements have developed from previous attempts at integration which, although not as successful, were positive developments that enabled thorny issues to be identified and resolved. Senior managers acknowledge that there is still progress to be made on a number of fronts and are not complacent about the need for further change. Importantly, Chief Executives across the region committed to the approach which enabled others to follow.

Trust was facilitated by the shared vision and the people centred approach, evidenced by putting the needs of the citizen first and allowing resources to follow the right decisions. A Joint Partnership Board of senior officials ensures the integrated approach and there is also a Change of Culture Board, chaired by the Council’s Head of Adult Services Board which meets monthly and brings together all managers across adult services. This is designed so that everybody feels part of the service and is able to provide feedback on their element. It also enables peer learning and has wider benefit by allowing issues in

other services to surface when compared to older people services. There is also a Transformation Team which is responsible for changing practice.

Issues like trust and mutual respect were identified as being more important than structural and technical issues, and it has all been driven by shared values. It was said that frontline staff "have to get it for it to work" so there has been huge investment of time in supporting staff to get to the point where they are seen to be driving the approach. Capturing patient/user stories has helped to reinforce the benefits and the adoption of the WCCIS shared information system not only demonstrates trust but facilitates it.

4.4 ROLE OF THE PUBLIC SECTOR WORKFORCE

Front line staff and managers are extremely positive about working in an integrated, person-centred way. Teams are co-located and each has a fully integrated team manager managing both health and social care staff and the associated resources. There are integrated job descriptions for the Integrated Community Services Managers of the CRT and networks.

No attempt has been made to harmonise terms and conditions of service and this has been regarded as sensible and pragmatic given the complexities involved. People in the new teams understand this and have continued their employment conditions following the change. The managerial posts were initially evaluated and placed within the Agenda for Change bandings which overlapped the local authority bands. This arrangement means that some managers are paid more than others but this is accepted as an inevitability of the integration and has not surfaced as a problem. There are some post-holders i.e. Occupational Therapists, employed by different organisations on different pay rates and although some inevitable dissatisfaction with this has been expressed by staff, it has not led to any significant grievance. Staff representatives have described the issue as a "niggle" and recognise that it has been a bone of contention amongst OTs in health and social care long before integration.

The focus of the change has been on what people do rather on what they are paid and there has been a considerable investment in time to engage staff to enable them to air their concerns and understand what the new vision means in practice. Staff confirmed that they are able to reduce bureaucracy and are empowered within agreed professional governance arrangements to ensure that people had the right support at the right time. They resolve problems through conversations and have begun to use devices which facilitate discussions such as "fishbowl" meetings.

The extensive staff engagement process flushed out issues and these related more to working practices, such as concerns about different documentation, rather than terms and conditions of service. Each agency nominated a human resource officer to work collaboratively on the HR aspects of the change and this proved invaluable in sharing knowledge and highlighting and resolving potential issues. Some innovative workforce structural components have been built into the integrated arrangements such as ensuring the three network teams are led by managers from both agencies. This contributes greatly to overcoming fears of "takeover" by either agency.

Another constructive approach has been to ensure each professional discipline has a senior nominated professional to whom staff can turn for professional decision-making and guidance. This ensures that people feel professionally confident and safe within the governance arrangements. An integrated

leadership programme was commissioned after tender from the University of South Wales. Managers have been trained in both sets of conditions e.g. leave of absence regulations, to ensure they are aware of staff's requirements.

A pragmatic approach to appointments has been followed whereby people's employment status is unaffected. The initial appointments process involved ring fencing opportunities to those regarded as being "in scope", i.e. directly affected by the change. Professional staff were slotted into their new posts and there was open competition within the "in scope" group for managerial posts. A joint consultation document had avoided any misunderstandings.

It was acknowledged that achieving the change outside any targeted savings agenda for the service was important and that achieving change is more difficult when budget cuts are involved. It was also acknowledged that getting staff from two agencies to buy in to the changes was easier than a wider multi-agency venture.

Some of the key lessons about the importance of front line staff which emerged are that:

- The hearts and minds of front-line staff must be signed up to the model – this takes time and patience;
- Staff must be empowered to deliver on the shared vision;
- Staff need to feel secure in their professional governance arrangements;
- There needs to be flexibility in approaches to human resources issues;
- You need clarity between management roles and responsibilities and professional leadership in matrix models;
- The commitment of middle managers is critical;
- It is important to develop integrated job descriptions and person specs where possible;
- Certain people are in prime positions to adopt change agent roles;
- Joint training helps develop the right skills;
- Fears about changes in culture and working practices are common in any change process. It is not unique to integration; and
- It is important to protect the professional identity of the disciplines (achieved here through dedicated professional leads and appropriate professional leadership within the integrated teams) so that it doesn't become an untidy mess.

4.5 ROLE OF ADDITIONAL FINANCE AND RESOURCES

The transformation of services for frail older and disabled people has been resourced by the realignment of existing budgets and by successful applications to the Integrated Care Fund for the delivery of the optimum model for the intermediate tier across Western Bay. The support for the roll out of anticipatory care has been led by the health board as part of its plans to support and develop the primary care workforce; the work has been developed and supported regionally. The development of the CIWT service was funded through the decommissioning of a traditional and underutilised model of care and the recommissioning and provisioning of a new service developed through analysis of gaps in service provision and consultation with disabled people.

The availability of ICF funding has also facilitated the implementation of additional integrated services. This has seen the introduction of a multi-disciplinary rapid response service, the Acute Clinical Team. The funding has enabled Bridgend to test projects such as its Better@Home service which provides social care services at a person's home whilst their short-term assessment service is being arranged thereby enabling people to leave hospital sooner. The Carers Centre has been funded to test a Carers Support Worker post, based within the Princess of Wales Hospital, which supports the facilitation of earlier discharges by being able to support Carers with their anxieties or concerns that arise during this different way of working.

Although the ICF has helped, its administration – short-term funding, late notifications etc. – has not. It was said that these issues make strategic developments more difficult to manage. It was also felt that the ICF's short-term nature stifled creativity.

4.6 ENGAGEMENT OF TRADE UNIONS

There appear to be good relationships with the trade unions in Bridgend. There was significant consultation about the change with staff and TU reps. Staff had been on board with the change and had been more worried about cultural change such as working practices than any issues about terms and conditions. Because of the extensive early involvement, the TUs had not needed to have been heavily involved at the stage when the staff were being deployed into the teams. It was important to note that the initial change process was not a TUPE exercise so the two employers had needed to respect differences in order for the change to move forward.

As the project had not involved job losses the TU had been fairly relaxed about the change. However, they were aware of "niggles" amongst staff which surfaced occasionally caused primarily by different pay rates and hypothetical questions about what would happen if there was in internal staff dispute, e.g. could one member of staff's grievance lead to another member's disciplinary, especially if two employers were involved.

The pay issue had arisen in respect of identical jobs, e.g. OTs who were employed by both organisations. Melding the different cultures was felt to be as big a challenge as matters affecting terms and conditions.

Local TU representatives confirmed that the decision to have a least one managerial post allocated to each profession had been an important way of avoiding any feelings of takeover or power battles and this had helped to build trust.

4.7 ROLE OF WELSH GOVERNMENT

The SSWBA and associated statutory guidance clarifies that care and support should be integrated around people to support them to secure personal well-being outcomes. The Act provides for new statutory partnerships between local authorities and health boards to drive integration, innovation and service change. Additional funding in the form of the Delivering Transformation Grant and Integrated Care Fund (ICF) has underpinned this and are critical components of facilitating change.

The aspirations of the Act were supported and the overall view was that progress to integration had preceded the Act, but that the Act gave authority to the local agenda and underpinned what was being

achieved. The approach in Bridgend replicates the three pillars of the Social Services and Wellbeing Act: better access to information and advice and universal services, proportionate early intervention, and managed care and support for those who need it. The integration of services has ensured that the principles of prudent Healthcare are replicated across community services: an evidence based, co-produced approach with citizens, ensuring that the right professional with the right skills responds at the right time.

The national policy direction and the Well-being of Future Generations Act are also viewed positively but Welsh Government was considered to be too fixated on certain metrics such as statistics around delayed transfers of care and should evaluate progress and performance in line with the bigger picture. The short-term nature of ICF and some of the mechanisms of its administration were felt to partly diminish the positive impact it has had.

4.8 ROLE OF "STRUCTURES" – INCLUDING THE RPBs AND PSBs

The principle followed in Bridgend was not to worry too much about structural matters in the first instance but centre thinking on doing the right thing for the citizen. Therefore, they didn't start with issues like governance – they started with Mrs Jones. That said, the importance of putting effective policies and procedures and other structural mechanisms in place, especially good governance arrangements, were understood and accepted.

Bridgend is a member of the Western Bay Regional Partnership Board covering the area of the Abertawe Bro Morgannwg University Health Board (ABMU). Bridgend's approach to integration is in the context of a commitment by the region to a whole systems approach to addressing the challenges of the issues presented by an ageing population. The RPB has been effective in governing the strategy and a Well-being Community Services Board reports to it. The RPB is seen as "something we're accountable to" and is an important player, demonstrated by the fact that a recent Ministerial visit was to the RPB not one of its constituent members.

Governance arrangements are supported by a senior officer led Joint Partnership Board which has responsibility for managing the integrated service and accounting for expenditure.

Some Section 33 agreements underpin part of the service and the budget arrangements but technically, the whole service is not regarded to have a pooled budget as there is no sharing of over and under spends. The arrangements are sufficiently flexible to allow money to be vired between services provided a robust decision-making process is followed. Everyone understands this and it does not cause any problems. The performance of the budget holder is overseen by the senior officer Joint Partnership Board.

There was not unequivocal support for strictly defined pooled budgets but total support for the notion of sharing resources. Pooled budgets were felt to create a great deal of bureaucracy and extra work, particularly for finance officers, which had not been properly considered. It was even suggested that they could inhibit integration because of the problems inherent in their administration, i.e. the principle was good but the practice caused sufficient problems to be a deterrent. This placed some doubt on their added net value.

Bridgend had undertaken extensive financial modelling which was based on examining the implications of not responding to changes needed to manage the increased demand compared with the opportunity to work differently. It was very much about ensuring resources were used to meet the increasing demand and ridding the system of duplication in creating a seamless efficient services. The arrangements in Bridgend was described by some as more of "an extensive paper exercise" than a pooled budget because there was no requirement to make savings in the same way as other budgets. This did not imply a lack of due diligence in formulating and meeting financial obligations.

4.9 "FRAGMENTATION" OF SOCIAL CARE

There are 15 independent domiciliary care providers on Bridgend's framework with 13 active and there are 22 residential and nursing homes. Independent providers are regarded as working well with the local authority and understand the approaches being followed. There is also a range of third sector providers and good involvement of the sector with the three network teams.

There are different pay scales, terms and conditions for health board and council staff but there is a willingness to work together, regardless of salary, terms and conditions. Staff are committed to their shared purpose and the partners have adopted shared information systems including growing use of the WCCIS.

The "fragmentation" of service delivery was not identified as an issue possibly because the market in Bridgend is relatively stable but also all because new referrals come through the integrated short-term assessment service before any care is commissioned. However, fragmentation of approach to the delivery of care, i.e. the adoption of different values and principles was considered to be anathema in respect of the integrated care agenda.

5. CASE STUDY – YNYS MÔN

5.1 DESCRIPTION OF THE NEED FOR THE INTEGRATED MODEL IN YNYS MÔN

A new service model has been developed in partnership with Betsi Cadwaladr University Health Board (BCUHB) and Isle of Anglesey County Council (IoACC) to provide care and accommodation to support people living with dementia who are presenting with increasingly complex health and social care needs. The new model will provide for 28 older persons aged 45 and above who are male or female on a long term and short-term basis who following a medical and multi-disciplinary assessment may have a diagnosis of dementia and presenting with complex health and social care needs but do not require nursing care.

This was prompted around 18 months ago when there was a shortage of older people's mental health (OPMH) nursing beds on the island which was evidenced at that time by a number of out of county placements and delayed transfers of care (DToC) data. The situation regarding both capacity and DToC has since improved (there is now not a problem with either currently) but there was a recognition that this was a problem that could resurface. Given the changing demography of people on the island, and the increased number of people living with dementia and people supported to live at home for longer, there was a realisation that demand for general residential care would be reducing and the need for OPMH residential and elderly mentally infirm (EMI) nursing beds increasing. This is all set in the context of the development of extra care facilities on the island along with more investment in community based services and strengthening of preventative interventions. Joint working with the health board has also been increasing.

In particular, for the last 18 months, the IoACC has been working with BCUHB to develop a service model to support people living with dementia who are experiencing distress and presenting with complex care needs. This has taken the form of a residential setting providing an enhanced dementia service, with facilities and staff with knowledge and skills specifically developed to support people who present with complex needs and who are experiencing distress.

5.2 GARREGLWYD

This new service model has been introduced at the Garreglwyd care home. Garreglwyd is situated on the outskirts of Holyhead, and is owned by Anglesey County Council. It is a purpose built care home constructed in 1991 to offer long-term accommodation to older people. The accommodation is divided into four units of single occupancy rooms. In short, Garreglwyd will provide the appropriate support and care service to people living with dementia and are presenting with increasingly complex care needs but do not require 24 hour nursing care. The home will eventually accommodate 28 adults, male or female aged 45 and above and who following a medical and multi-disciplinary assessment who may have a diagnosis of dementia on both a long and short-term basis. Individuals must meet the criteria for the service and must not require 24 hour nursing care.

In order to support the change from older people's residential home to one providing the new enhanced dementia service, the 20 staff have been provided with additional training programmes, and

have shadowed those working in EMI homes elsewhere on the island. The current staff group are now experienced in dementia care and they hold a range of QCF Level 2 and 3 Diplomas. The key change in the service model that facilitates the delivery of the enhanced model is that the care home staff are now working in an integrated team environment. The care home staff are supported on a daily basis by a community psychiatric nurse (CPN, three of whom have been employed from ICF money to support this new model based at Ysbyty Cefni) and a district nurse (DN). Social care support is therefore provided by IoACC staff with specialist health care provided by BCUHB in the shape of increased CPN and DN capacity which prioritises support to the care home. The core hours of the enhanced specialist health service are between 8am-8pm with in-reach service available. Out of hours telephone support is available from Ysbyty Cefni, in Llangefni. The GP out of hours service is also available to the Care Home. District Nursing in reach service will be available within the Out of Hours nursing services and a Registered Nurse/Health Care Assistant will be available to respond up to 8am. This can either be assistance by phone or if needed a physical presence at the care home.

As a minimum therefore, daily updates and review are part of the individual`s service plan reviewing process. This involves detailed discussions between the care home staff with the CPN and DN on all individuals at the home. Any new issues are addressed at this point and the appropriate individual service plan amended accordingly. This will be signed off by the Allocation Panel and recorded in the MDT service delivery plan.

Individuals can be referred for a placement at Garreglwyd through the Adult Services Care Management team and directly from a hospital setting. The care home will ensure a comprehensive assessment of the individual's needs is undertaken. Placement will only be agreed when the multi-disciplinary team (MDT) are satisfied that the care home can meet the individuals` assessed care needs. The MDT meets at Garreglwyd every two weeks so decisions are taken quickly and involve all the relevant professions. Once the offer of placement at Garreglwyd is agreed a person-centred care plan for the individual is prepared and a multi-disciplinary service delivery plan developed with the individual and relatives. The care plan is subject to an MDT review as appropriate and the service delivery plan is reviewed at the care home by the as a minimum on a monthly basis.

5.3 ORGANISATIONAL LEADERSHIP OF THOSE DELIVERING THE INTEGRATED ACTIVITY

In terms of the issues underpinning the Garreglwyd service model, the leadership of those involved in the two key delivery organisations has had a huge impact on the way in which the model has evolved. The leaders adopted a very positive attitude about they could do, deciding things together. They were honest with each other in their discussions about what couldn't work and what could and in the strategic group this honesty led to the development of a partnership that was supportive.

Having partnership agreements under Section 33 was not deemed to be a pre-requisite but was very useful in bolstering the governance arrangements and covering off any doubts that people may have had at the outset of the process. It clearly stated that the operational responsibility would sit with the IoACC, and the clinical accountability would sit with BCUHB. However, several of the leaders when discussing the partnership were not even aware that a Section 33 agreement was in place – which is interesting, and makes the point that the strength of their relationships was more important than processes in moving the new service model along.

There is a long-standing belief in the locality about the cultural needs of the community. Many of the leaders live in their own communities and want to deliver for their own communities and relationships have built over time – their history helps. The organisations are now much closer – and in part, the fact that the health board has been in special measures for a sustained period has meant that the organisational leaders have been required to think differently and work in partnership differently.

It was also noted that because of the good working relationships the locality feels that they are on a good footing because they are building on success – it was suggested that starting small and then building up is the right way to embed effective integration.

5.4 RELATIONSHIPS BETWEEN "KEY" DECISION MAKERS

Linked to the issues around organisational leadership, are the behaviours and the relationships that operate between the leaders of those organisations. Key to this is to recognise issues of common purpose, and having the right people around the table. People were honest enough to say that this was not an absolutely smooth process, but the relationships made things happen. The attitude of the key decision-makers was that they were not going to let institutional issues get in the way. This came down to people wanting to achieve for people – rather than an organisation wanting to achieve for itself. These ideas and principles united people around the table – it was understanding that there were shared challenges but also shared glory. It was identified that good staff and good people with the right sort of values make the difference to making the integration change work.

These relationships were not developed overnight, and have been established over many years. There is a pre-existing culture and history of blurring the boundaries and trusting each other's professional judgement in this part of North Wales. Whilst these relationships were not identified as an essential prerequisite of developing integrated service models –it was felt that you can make these changes happen without the pre-existing relationships – the perception was that it would take much longer to achieve. People suggested that finding the 'win-wins' is crucial, and that this is difficult to do unless you have the underpinning trust.

5.5 ROLE OF THE PUBLIC SECTOR WORKFORCE

The new service model has required the frontline workforce – all of whom are either employed by IoACC or BCUHB – to change its way of working. Previously, Garreglwyd was an older people's residential home, which for the last five years has been under threat of closure or sale. This change of purpose was discussed and the staff within the care home were excited about it, in no small part because it would, if successful, provide a secure and sustainable model for their employment. It was recognised that all change is difficult but the staff group within the home have been fantastic – there are 20 people on the books as care workers, and almost all of them have embraced the change. It hasn't always been easy but the staff have been keen to be challenged and to think about working differently.

As mentioned above, the care workers have been supported in lots of different ways. During Q2 and Q3 of 2017, the staff undertook an intensive training programme so that they would be ready to provide the enhanced dementia service. They were able to visit EMI nursing homes and EMI residential

homes to get a sense of how other care workers do their role and to learn from them. The IoACC also brought in some specialist care support to raise awareness around dementia.

The care home staff now work as one team. Having the daily advice of the CPNs onsite is perceived as excellent and it helps the staff team, and it was certainly felt that the Garreglwyd set-up is a mutually beneficial one – in that it supports both sets of workers incredibly well. Having the additional support of the CPNs has been really positive, especially in mentoring the care home staff. That said, at the outset (from January this year onwards) some of the care workers felt that the CPNs were there to watch them interacting with the residents, and form a judgement about their care. This lead to some care workers feeling nervous as they felt that the CPNs were "looking over my shoulder and judging". What has happened as time has passed and the new model has become established, is that the care workers have come to recognise that whilst the CPNs might ask questions about people, they also offer useful hints and tips about doing things slightly differently. That was felt to be a real positive as it has allowed the care workers to do their jobs more effectively. There is a now a mutual trust and respect, and the care workers in particular felt that having the CPNs on hand to discuss issues is really positive – they are now acting like mentors for the staff, offering their expertise.

An important factor in making the change, has been that the terms and conditions and line management responsibilities of the frontline workforce have not changed at all. This has been a real help in the process – the frontline managers recognised the importance of not trying to do too much too soon. Similarly, the staff have had time to bed in the new way of working. They've been at relatively low capacity in terms of residents to date, and accordingly lots of the challenges are going to emerge as new wings open and the number of residents increase. As noted above there are three employed CPNs and one DN that support the work of the care home staff – those proportions aren't going to change as Garreglwyd moves from having six residents up to 28 over the next 12 months. The next bedded wing of eight is going to open in the next couple of weeks, and there was an expressed desire to ensure that the staffing levels go up to the right ratios, to keep the model working well together.

There was a recognition that recruiting the CPNs and DN was a challenge. Recruitment issues are compounded the further west you come across North Wales, although it was suggested that having a problem in recruiting DNs was a newer issue. It was also recognised that in another 12 months, the care home staff will be skilled and specialised, and some thought now needs to be given to thinking about the career pathway for those care workers. This might mean seeking to identify where there is deficit in the care home market, and whether there is scope for thinking creatively about other integrated models of care. What matters for now to the frontline care workers is to do their jobs as effectively as possible, trying to do what they've always done and give people a sense of dignity and respect. They know that every day is different and what worked with people yesterday won't necessarily work tomorrow, but that keeps them "on their toes" to keep improving.

5.6 ROLE OF ADDITIONAL FINANCE AND RESOURCES

Of central importance in making the move to an integrated service model in Garreglwyd, was the revenue and capital provided by the Welsh Government's Integrated Care Fund (ICF), with many people going as far as saying that having the ICF money was crucial and that this wouldn't have happened without it.

Echoing the points made above, it was suggested that in North West Wales, the ICF allocation very much feels like a pooled arrangement. Projects are agreed across the sub-region as a group, ad in some ways the ICF brought people and organisations together as there was an opportunity to use the resource to develop new service models. The early meeting were made very much smoother because the financial question about who pays had been resolved – neither organisation had to find this revenue which meant that everyone saw this as a 'win, win'.

Overall the staffing budget is for Garreglwyd is less than an EMI nursing model alternative, but key leaders noted that they were driven primarily by the need to think about the sustainability of this service model, and that there is a genuine commitment to the community to continue with the model at the end of the ICF funded period. Linked to this, it was noted that it is important to understand how this new model works and the difference it makes. There are hopes of ascertaining the impact of this new service model on flow and DToC, and whether it reduces hospital admissions. There is a desire to ensure that the evidence-base leads future decisions about the model to ensure that it provides value for money.

5.7 ENGAGEMENT OF TRADE UNIONS

Interestingly, there was no engagement of trade unions representatives in the development of the Garreglwyd model. There was a recognition of needing to do more to optimise this engagement in future discussions about integration, and a commitment so to do.

5.8 ROLE OF WELSH GOVERNMENT

The proposed enhanced dementia model was discussed at the outset with CSSIW. The initial meeting was very encouraging and they laid out their expectations in respect of the Statement of Purpose and the level of detail required. Subsequent involvement from CSSIW included site visits and evidence of staff training and governance arrangements before agreeing to the new registration. Notwithstanding the previous comments in respect of ICF funding as an important enabler of this new service model, there was very other little direct comment on the role of the Welsh Government. The impact of new legislation was recognised in broad terms, but overall it was felt that the changes at Garreglwyd had very little direct connection to the role of the Welsh Government.

5.9 ROLE OF "STRUCTURES" – THE RPB AND PSB

In a similar manner, the RPB did not significantly influence the development of the Garreglwyd model, however they do take an oversight of all ICF funded projects across North Wales. It was suggested that the RPB is too big in scale across North Wales to influence all of the projects and forging effective relationships at that scale is very challenging.

Some perceived a strategic disconnect between the RPB and the PSB, as the agendas of the two don't come together, they report in different ways and have different accountabilities both locally and nationally. The positive working relationships and logic of the sub-regional PSB 'footprint' of Gwynedd and Môn was suggested as the most natural scale upon which health and social care should be integrated. Beneath that were a range of structures at an Anglesey scale that were thought to be very helpful. There is a connection between this work and the 'care closer to home' strategy.

Overall, it was felt that this example of integrated working is still in its early days, and that the next task is to recognise what is being learned and what difference the new model is making as it develops.

6. CONCLUSIONS

In drawing conclusions from our research, we have drawn on three key elements:

1. What we learn from the literature on health and social care integration that relates particularly to the scope of this research project;
2. The findings from the three case studies in Bridgend, Monmouthshire and Ynys Mon;
3. The relationship between our findings and the report of the recently published Parliamentary Review of Health and Social Care in Wales.

These three elements provide a picture of integration to date, at present, and in the future and are used to arrive at an overall conclusion.

6.1 CONCLUSIONS FROM THE LITERATURE

The literature pertaining to the scope of this research project suggests that it must be recognised that a wider, more complex collaborative challenge rests with a cross-sector agenda, notably health and social care integration. In this regard, it will be necessary to make more systematic use of available guidance on how to achieve greater collaboration and integrated working if the pace and scale of integration in Wales is to accelerate. Four notable examples are:

1. The King's Fund guidance (2013)[12] which contained a 16-point plan for increasing the scale and pace of integrated care whilst recognising that changes to national policy and to the regulatory and financial frameworks are needed for local leaders to fully realise a vision of integration.
2. The previously referred to SSIA guidance (2013) on collaboration in social services in Wales which produced a checklist of some 80 questions to support local authorities and their partners in their collaborative endeavours.
3. The Social Care Institute for Excellence Logic Model (2017)[13] which provides a framework for addressing integration that includes identification of the enablers and components of integrated care together with expected outcomes and impacts.
4. The integration self-assessment tool produced jointly by the Local Government Association, NHS Confederation, Association of Directors of Adult Services and NHS Clinical Commissioners (2016)[14] which focuses on the key elements and ingredients needed for successful integration.

[12] King's Fund (2013) *Making Integration Happen at Greater Scale and Pace* – accessible from: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/making-integrated-care-happen-kingsfund-mar13.pdf

[13] SCIE (2017) *Logic model for integrated care* – accessible from: https://www.scie.org.uk/integrated-health-social-care/measuring-progress/logic-model

[14] LGA et al (2016): *Stepping Up to the Place: Integration Self-assessment Tool* – accessible from: https://www.local.gov.uk/sites/default/files/documents/stepping-place-integratio-a3d.pdf

We can also now consider integration in the context of the documentation referred to earlier which was produced this year by the Parliamentary Review team regarding seamless, community-focused health, social care and well-being for older people in Wales.

It can be argued that the imperative now is to use guidance such as these and find the right way of making integration and collaboration work meaningfully and consistently and not slowly and sporadically as claimed in some of the evidence submitted to the Commission on Public Service Governance and Delivery in Wales (2014).

Advancing the overall collaboration agenda appears fundamental to achieving integration of health and social care. In the case of the latter the case for integration can be readily understood alongside the concept of achieving "collaborative advantage" which is defined as being achieved when "something unusually creative is produced – perhaps an objective is met – that no organisation could have produced on its own and when each organisation, through the collaboration, is able to achieve its own objectives better than it could alone. In some cases, it should also be possible to achieve some higher-level….objectives for society as a whole rather than just for the participating organisations".[15]

The formation of inter professional teams (IpTs) has brought the issue of leadership to the fore with the challenge of enabling sometimes differently skilled workers to co-ordinate their efforts and work more closely together than was traditionally the case. The literature identifies a specific leadership function for the team itself, with a focus on shared, collaborative or collective leadership. It also highlights a leadership function as requiring a person who can promote transformation and change and support creativity and innovation as key elements of their role. [16]

Some elements of leadership practice may be particularly effective in inter professional team settings. The key issue is the fact that the operational workforce within health and social care is predominantly multi-professional in nature and necessitates working together in a more integrated fashion. The creation of IpTs has therefore created a unique leadership context. The fact that leaders come from one profession or discipline, and cannot therefore demonstrate greater professional expertise in other professions, makes IpT leadership more demanding as the team leader needs to find a way of leading a diverse workforce and to find ways to persuade an inter professional group to give up professional autonomy to integrate their practices and operate as a team.

A key message from the literature is that integration will not work without effective leaders and positive use of the workforce. It is suggested[17] that there are three key steps for workforce leaders who promote integration: be clear about the local integration agenda; address the integrated workforce management challenge; and implement successful workforce change. It is also important to

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[15] Huxham C (1993) "Pursuing Collaborative Advantage" *Journal of the Operational Research Society* Vol. 44, pp.599-611: https://www.tandfonline.com/doi/abs/10.1057/jors.1993.101

[16] Smith T, Fowler-Davis S, Nancarrow S, Ariss SMB and Enderby P (2018) "Leadership in interprofessional health and social care teams: a literature review" *Leadership in Health Services*: https://doi.org/10.1108/LHS-06-2016-0026

[17] Centre for Workforce Intelligence (2013) *Think integration, think workforce: three steps to workforce integration – accessible from:* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/507666/CfWI_Think_Integration.pdf

be clear from the outset about the form of integration best suited to meeting local needs as it can apply in different contexts, such as care pathways, workforce teams, management and governance and commissioning and planning.

Understanding the role of government in achieving integration, especially when it involves the provision of additional funding, is also necessary. It is understandable that government could claim that a blend of prescription and enablement is the right approach but this is a complex objective and, arguably, requires a new formula in the light of the complexities identified. For example, the prescription of different regional partnerships for different functions has provided flexibility but also allowed local authorities to question the logic of the government approach.

Targeting grant funding, particularly via the ICF, to regional approaches brings strategic clarity but can also discourage other models of less formal, network type governance. A recent review[18] of the ICF in Wales, however, demonstrated that the additional funding had been used flexibly; ICF projects had used different means to help agencies work in an integrated way, the third sector had played a key role in many projects and ICF funded projects had demonstrated their contribution to promoting independence and preventing escalation of need.

Research undertaken in Scotland[19] highlights that there is no "one size fits all" design for integration. It needs to be sensitive and responsive to the particular geographic, financial, policy and professional features of a particular locality. At the same time, there needs to be a considered judgement that reaches an appropriate balance between excessive fragmentation at the local level and standardisation which is insufficiently responsive to local characteristics. The success of integration is linked inextricably to the context in which it takes place. Key factors in achieving integration needing to be addressed are considered to be vision, time, leadership, integrated teams and the local context and culture. There is a particularly close interaction between the dimensions of vision, outcomes and leadership. Outcomes should form a major component of the vision, likewise strong leadership is needed to transform the focus from inputs and outputs to outcomes.

Fully integrated care is likely to include an important contribution from the third sector and research[20] in this context suggests:

- Collaboration is resource intensive and requires time, money and senior involvement.
- Care must be taken to avoid top down decision making which can lead to smaller organisations struggling at times to see how an initiative fits with their priorities and resources.
- Looking ahead, there are challenges about demonstrating the practical impact of new ways of working. Outcomes can take time to be achieved.

The involvement of the third sector in efforts to integrate helps us understand the challenges of achieving effective collaborative governance arrangements particularly in ensuring that the

[18] Welsh Government (2017) *Review of ICF – projects and initiatives which demonstrate good practice*

[19] Petch A (2013) *Delivering integrated care and support*: IRISS – accessible from: https://www.iriss.org.uk/sites/default/files/2016-07/iriss-delivering-integrated-care-and-support-2013-12.pdf

[20] Joy I, Boswell K, Grewal S and Patel S (2018) *Tapping the potential – lessons from the Richmond Group's practical collaborative work in Somerset* – accessible from: https://www.thinknpc.org/publications/tapping-the-potential/

participants share a common reason for playing their part. It is suggested that it is a need to exchange resources and negotiate a shared purpose that brings the state and not state participants together and that the resulting governance network is characterised by interdependence between organisations. [21] This interdependence must not be skewed by an imbalance in power. Previous research in respect of cross sector working in Wales[22] found that power disparities between representatives from different sectors could also inhibit the participation of some partners. It has been suggested that, in relation to shaping power relations in attempts to integrate health and social care, tangible objects, such as the layout of buildings or intangible objects such as ideas, can represent power structures and be powerfully symbolic.[23]

The integration agenda is increasing in significance across the UK demonstrated by NHS England stating that "Our aim is to use the next several years to make the biggest national move to integrated care of any major western country".[24] This is being done through new care models, sustainability and transformation plans (STPs) and the evolution of some STPs into integrated care systems. The King's Fund report in which this statement is included looks at developments in England and the work underway in the integrated care systems and at NHS England's proposals for an accountable care organisation contract. One aspect considered by the report is whether this will lead to privatisation and the report concludes that the biggest risk to integrated care is organisational protectionism, rather than privatisation, linked to a history of competitive behaviours and sometimes poor relationships between the leaders who need to collaborate to make a reality of integrated care. The research has found that progress is more rapid where effort has been invested in building trust and collaborative relationships at a local level, and with sustained commitment.

This may provide some comfort to both UNISON and the Labour Party in Wales who have produced policy statements suggesting that there is no room for further privatisation in Wales. Their view is that experience shows that outsourcing public services to private companies or the community or voluntary sector can often have a negative impact on the services themselves. The importance of trust in achieving integration cannot be overestimated and some leading authors on collaboration[25] have reported a "gap between the common wisdom that trust is necessary for collaboration to be successful and common practice, which suggests that trust is frequently weak (if not lacking altogether) and suspicion is rife". It is argued that the solution rests in understanding that trust building must be a cyclical process within which positive outcomes form the basis of trust development, thus forming a

[21] Fenwick J, Miller KJ and McTavish M (2012) "Co-governance or meta-bureaucracy? Perspectives of local governance 'partnership' in England and Scotland" *Policy and Politics*, Vol.40, No.2, p.405-22

[22] Sullivan H and Williams P (2009) "The Limits of Co-ordination: Community Strategies as Multi-purpose Vehicles in Wales" *Local Government Studies*, Vol.35, No.2, 161-180

[23] Sullivan H and Williams P (2012) "Whose kettle? Exploring the role of objects in managing and mediating the boundaries of integration in health and social care" *Journal of Health Organization and Management,* Vol. 26 Issue 6 pp.697-712

[24] Ham C (2018) *Making sense of integrated care systems, integrated care partnership sand accountable care organisations in the NHS in England.* The King's Fund – accessible from: https://www.kingsfund.org.uk/publications/making-sense-integrated-care-systems

[25] Huxham C and Vangen S (2005) *Managing to Collaborate: The Theory and Practice of Collaborative Advantage* UK: Routledge

trust building loop, acknowledging, however, that this conceptually appealing loop is at odds with numerous complex factors such as membership of the collaborative venture, its structure and imbalances in power.

6.2 CONCLUSIONS FROM THE CASE STUDIES

The case studies provide a snapshot, but nevertheless significant, view of health and social care integration in action in different parts of Wales. It should be noted that the emphasis of this research was on the processes that supported successful integration rather than the outcomes but this should not detract from the positive outcomes that each was able to demonstrate. We have analysed the key factors in achieving integration which emerged from the interviews we undertook and present a summary of them in the table below in rank order of importance. Our findings very much chime with the key messages emerging from the literature. Taking each factor in turn we provide some additional detail to explain each.

THE ORGANISATIONAL LEADERSHIP OF THOSE DELIVERING THE INTEGRATED ACTIVITY

We sought to discover the way in which the leaders of the relevant organisations, across different levels, worked together, and how they approached issues like evolving governance arrangements. We discovered strong and clear leadership in each case, with clear direction about the outcomes that the integration was seeking to achieve. We saw evidence of senior leaders committing themselves to supporting an integrated approach and following this up with support for those below them to make it happen, beginning with establishing clarity of what was expected. The creation of a shared vision from the outset appears to be critical in maintaining support for integration through complex implementation phases with a shared clarity about aims, and creative thinking about “How we can make this work.”

By definition, leaders have to have followers and this strong and clear leadership by people at the top of the organisations means that there must be no room for confusion about the commitment to, and intention of, the approach. This is not to say that there must be a top down approach to delivering integration as we found evidence in our case studies of a real desire to engage staff at all levels and develop a mutual understanding of what would work best – a real investment in the people who would ultimately form the integrated frontline. Leadership in moving the agenda forward has been demonstrated by front line staff, notably in the case of the beginnings of the Raglan project, where their willingness to share issues, together with the openness of management, led to a significant change. Moreover, by concentrating on the care and support needs of the individual and the feelings of frontline staff, it could be argued that the approach is in fact more bottom up. Additionally, the need for leadership to be effective at different levels to take account of the challenges of managing integrated teams was evident in the respect shown by team members for their different disciplines. Much of this was achieved by enabling staff the facility to share knowledge about what they did and how they did it.

We would conclude that leadership is essential at all levels demonstrated by the leadership we saw in moving the agenda forward shown by frontline staff, where their willingness to share issues, coupled with an open approach by management colleagues, led to significant change.

KEY FACTORS IN ACHIEVING INTEGRATION – FINDINGS FROM THE CASE STUDIES

Most important factor in achieving integration

Key factor	Description of key factor	Rank
1. Organisational leadership of those delivering the integrated activity	*This covers the way in which the leaders of the organisations across different sectors and levels who are directly involved in delivering the integrated activity work together, and how they have ensured successful implementation of a sustained integrated approach.*	= 1
2. Relationships between 'key' decision-makers	*This focuses on the personal relationships between those people 'around the table' including the trade unions who initiated and have seen through the integration. These relationships had been forged over time and had allowed trust to build.*	= 1
3. Role of the public sector workforce	*The way in which the 'frontline' workers and managers have responded positively to a change in service delivery/model has impacted significantly on the ways in which these three case studies have been successful. Trade union leaders have contributed significantly in two of the three case studies in this regard, and innovative Human Resource management approaches have supported staff to work successfully in integrated teams.*	2
4. Role of additional finance and resources	*The importance of external and additional finance (primarily via the Integrated Care Fund [ICF]) cannot be overstated – it has enabled and catalysed the integration activity.*	3
5. Formal mechanisms for the trade unions to engage with the process	*In two of the three cases, the role of trade union representatives in contributing to, determining, and supporting the new the integrated services has been invaluable and the challenge ahead is for the trade unions to become part of the leadership arrangements. It is important to note that the role of the trade unions was an important facet in factors 1, 2 and 3 above.*	= 4
6. Role of Welsh Government	*The role of the WG – chiefly around new legislation, policy and the financial support offered by ICF – is perceived to have largely been positive in helping to achieve integration but funding regimes need to be better geared to long term sustainability and more flexible to access.*	= 4
7. Role of 'structures' including governance	*Whilst there are Section 33 agreements in place and these are valuable, pooling resources has not depended on strictly defined pooled budgets. There is a mixed picture regarding the role and relevance of the RPBs, and the PSBs, further complicated by the fact that the PSB in one of the case studies is sub-regional (i.e. not tied to the local authority footprint).*	5
8. 'Fragmentation' of social care	*Perhaps surprisingly, the fragmented nature of the frontline workforce (whether independent or third sector) has been somewhat irrelevant in the examples of integration studied but achieving seamless services remains a primary objective.*	6

Least important factor in achieving integration

RELATIONSHIPS BETWEEN 'KEY' DECISION-MAKERS

Here we focus on the personal relationships between those people 'around the table' who initiate and see through the integration. In our case studies, these relationships had been forged over time and had allowed trust to build. Therefore, the structured approach achieved through factors like good programme management was cemented by a depth of mutual trust. Organisations are not inanimate bodies functioning by mechanisms and procedures alone. They are dynamic entities influenced by the people who constitute them and the trust element epitomises our conclusion that, however important structures and formats of integration may be, getting the people factors right is greater.

Trust obviously needs to be earned over time, built upon years of experience of working together, and we noted that time and space had also been allowed for staff from the different agencies to develop trust in each other. This investment in time helps to provide a robustness and sustainability to the integrated approach and a tolerance and respect of the abilities and constraints on people in the teams. For example, staff said that an important reason for working in an integrated way was the fact that their work is completely people centred. They have authority or "permission" to act, and a mantra is "We trust the judgement of front line staff". There are inevitably issues which arise, some of which challenge professional boundaries but staff felt that by working in an integrated way they were able to reduce bureaucracy and ensure that people had the right support at the right time. We are convinced that achieving integration cannot be rushed.

An area needing further development is information sharing. Although co-located team members are able to share information fairly freely via discussions about individuals, systems and procedures are not yet set up to enable information sharing to take place routinely between agencies. We saw shared approaches to this in the case studies including use of the new WCCIS system in addition to more bespoke locality-driven approaches and feel that unless this is addressed systematically across Wales it will remain a major obstacle to achieving a fully integrated approach. The progress we saw in our case studies is indicative that this perennial nut can indeed be cracked with the right commitment and conditions.

ROLE OF THE PUBLIC SECTOR WORKFORCE

We discovered that the way in which 'frontline' workers and managers have responded positively to a change in service delivery/model has impacted significantly on the ways in which these three case studies have been successful. The clear vision, begun by senior leaders, had undoubtedly been embraced and implemented by those on the front line. The needs of the person needing care and support, illustrated by Bridgend's fictitious Mrs. Jones, was sacrosanct in the manner in which people approached their jobs and this served as a strong unifying agent for the integrated teams. They had effectively developed a common cause and were able to rely on conversations to overcome problems rather than formal procedures.

We also noted that staff had expressed genuine concerns about changes in culture and working practices and, to a lesser extent, potential threats to their terms and conditions of service. These had been overcome through meaningful engagement processes and time and patience in allowing perceived difficulties, large and small, to be worked through. We saw evidence of innovative work by

Human Resources officers from different agencies working together, e.g. integrated and aligned job descriptions, and the adoption of a pragmatic approach to overcome potential barriers such as different pay rates. We also saw evidence of ongoing training and support as the move to integrated models requires an ongoing effort to support this work. Joint training was another example of an acknowledgement that staff needed ongoing support. The result is that some potentially big problems are reduced to "niggles" and natural fear about integration converted to an acknowledgement that it can be challenging but also very rewarding.

Respecting and supporting the workforce as assets on which the new approaches will depend is fundamental to achieving successful change.

THE ROLE OF ADDITIONAL FINANCE AND RESOURCES

The importance of external and additional finance cannot be overstated. It has enabled and catalysed the integration activity. The Integrated Care Fund [ICF] featured in all three cases and in respect of Ynys Mon, enabled the initiative to take place. In one case, the Health Board had invested significant funds in converting a hospital facility into office space which enabled an integrated team to be co-located. We live in an era of austerity where the emphasis of public sector budgets has been on cuts not growth. Research suggests that integrated care is not necessarily a cost saver but is a service improver and as such should be positively regarded in terms of both efficiency and effectiveness. Being able to see the longer-term benefits of the integrated approach through investment is crucial, whether this be via external or internal funding and, whilst we acknowledge the challenge this presents, should not be regarded as optional when considered in terms of statutory requirements and the needs of the population.

MECHANISMS FOR THE TRADE UNIONS TO ENGAGE WITH THE PROCESS

In two of the three cases, the role of the trade unions in contributing to, determining and supporting the new the integrated service was invaluable. Bearing in mind the importance placed on engaging and gaining the support of the workforce to the change, it is unsurprising that we conclude that engaging their representatives is also important. It could be argued that the strength of the case for integration and the sign up to a clear shared vision would have been strong enough factors to have ensured successful implementation of the change but this belies the need to provide assurances to staff which trade union representatives are uniquely placed to do. The challenge for the trade unions is to increase their level of understanding and commitment to the integrated approach to a point whereby they are genuine partners and leaders in the change process.

ROLE OF WELSH GOVERNMENT

We assessed the role of the Welsh Government chiefly in respect of their roles in creating new legislation, policy and providing financial support. Overall, we conclude that Welsh Government's role is perceived to have largely been positive in helping to achieve integration evidenced by the importance of the Social Services and Well-being (Wales) Act 2014 making it a statutory duty on health and social care bodies to cooperate and the significant additional funding offered through the Integrated Care fund. However, the inability to make the ICF core, recurring funding has resulted in uncertainty about

the sustainability of integration initiatives which in turn has led to some perceptions of the Government's contribution being diminished. The administration of the fund also mitigates against agile, flexible strategic planning. These issues have to be addressed if people are to move the integration agenda forward with confidence.

ROLE OF 'STRUCTURES'

We explored the role of structural factors on a number of fronts including the presence of pooled budgets and the extent to which organisational factors, such as rules and procedures had played a role in achieving the change. We were particularly interested in assessing the role of evolving governance arrangements, namely the Regional Partnership Boards and the Public Service Boards.

We discovered that there is a mixed picture regarding the role and relevance of these bodies, further complicated by the fact that the PSB in one of the case studies is sub-regional, and not tied to the local authority footprint. In one case, the RPB was deemed to be an important body to which people felt accountable but this was not so evident in the other case studies.

Whilst there were s.33 agreements in place, and were viewed as a positive development, our conclusion about the necessity of formal financial agreements and pooled budgets is that they must demonstrate their necessity rather than be considered a pre-determined pre-requisite. We base this conclusion on the relatively relaxed view taken of them by the case study participants, i.e. people were glad to have them but were committed to achieving an integrated approach whether they were in place or not. However, the need to have a shared approach to using resources was considered much more fundamental than any mechanisms to achieve that objective.

The emphasis on getting things right for the person in need helps to render arguments about whether structural or organisational integration is a good thing as somewhat irrelevant.

'FRAGMENTATION' OF SOCIAL CARE

Given the fact that integration is often described as the opposite of fragmentation, we were keen to explore whether the delivery of services through a number of different agencies affected attitudes and approaches to integration. Perhaps surprisingly, the fragmented nature of the frontline workforce (whether independent or third sector) proved to be somewhat irrelevant in the examples of integration studied. However, when fragmentation of service delivery was considered in the context of being disjointed, people emphasised the value of seamless, coordinated services.

We conclude from this that language is important when discussing integration which is itself a term open to various interpretations. A mixed market approach does not appear to be a concern other than when it affects coordination of care, i.e. when the number of agencies involved is too great to achieve the coordinated approach being sought. Joint commissioning has not yet been universally achieved and this may prove to be the best defence against unwanted fragmentation of care.

UNDERPINNING RISKS

It is important to note that there are a number of underpinning risks to the continuing success of integration projects and programmes in Wales. Principal among these is the role of additional finance.

The risk associated with the finances (and the sustainability thereof) is matched by the important of the continuity of key people in each of these integration examples, and the potential threat posed to governance issues should the people 'around the table' change significantly. The degree to which the trades unions have been involved is also a risk for the future – there was a real positive of ensuring in Monmouthshire that UNISON reps were fully engaged, and there is an associated potential problem where they are left 'on the sidelines' of the ways in which new integrated service models are developed. This finally links to the risk of not doing enough to ensure that in these new models, terms and conditions are harmonised effectively, which can breed distrust and resentment.

6.3 CONCLUSIONS RELATING TO THE PARLIAMENTARY REVIEW

Many of the central messages of the Parliamentary Review are consistent with the findings and conclusions from this research project. The review team's report prioritised the need for "one system of seamless health and care for Wales…without artificial barriers between physical and mental health, primary and secondary care or health and social care". It also emphasised amongst its quadruple aims the importance of the workforce and, throughout its report, referred to the need for strong leadership. The importance of getting funding regimes right was referred to in the report's recommendation to align system design to achieve results and, of course, by aiming its recommendations at Welsh Government, it was essentially reinforcing the correlation between the role of government and the fulfilment of strategic aims.

We recognise that the remit of the Parliamentary Review was far reaching and that its reference to seamless services was wider than recognised interpretations of integrated care. Nevertheless, we believe it is right to locate this research study in the context of the Review's recommendations. The additional document produced by the team to inform recommendations on how to secure seamless, community-focused health, care and wellbeing services for older people in Wales contains numerous references which are relevant to this report and which featured in the case studies. The following illustrate this:

> *"Co-location and close working between health and social care staff will mean that it is possible to mobilise resources much more quickly and easily to respond to crises or get patients out of the hospital and home."*
>
> *"Hospitals and care homes will work more closely with these seamless primary care services and work with them to identify and act to support particular patients or communities."*
>
> *"The Social Services and Wellbeing Act promotes greater integration between health and social care with requirements for joint working, including for example, developing an understanding of local needs, the extent to which these are being met, and the services required to meet them."*

"A care culture orientated towards the outcomes the citizen wants and can achieve: 'what matters to me'."

"Staff should have fulfilled and productive working lives and work towards continuous quality improvement."

Perhaps most significant is the fact that the work going on in both Monmouthshire and Bridgend featured in the document as being considered by the panel to be most aligned with the principles outlined in recommendation 3 of the final report of the review, "Bold New Models of Seamless Care - national principles, local delivery".

We therefore conclude that the lessons learned from our case studies support the strategic direction proposed by the Parliamentary Review and should be used as an additional resource to fulfil the Review's intentions.

6.4 SUMMARY

We feel it would be helpful to draw our conclusions from our three elements together in a number of key messages for those attempting to achieve a more integrated approach to health and social care in Wales.

- **Use the guidance already in place.** The research on integration has expanded since the King's Fund published its "Scale and Pace" 16 point plan in March 2013 but its messages in relation, for example, to leadership, establishing a shared vision, providing time and space, and using the workforce innovatively were vividly evident in our case studies and undoubtedly still relevant.
- **Demonstrate strong and clear leadership.** Organisational leaders must visibly commit to the integrated way of working and back this up with support for others to achieve the aim.
- **Ensure the vision is clear and shared, and based on the needs of the person/patient.** Reinforce that vision especially when difficult situations have to be addressed.
- **Value the knowledge and expertise of front line staff, investing in those expected to deliver the aim.** Integration cannot be rushed; allowing time for people to understand what it is and isn't enables it to be sustained in the longer term. Facilitate opportunities for staff to share knowledge and experiences, and learn from each other through conversations, meetings and training. Value their knowledge and expertise and build on existing good relationships to form new ones, recognise that trust must be earned and an imbalance of power neutralised. Make a shift in terms of conditions – like providing salaries for care at home workers – and put in place pathways for the career development of frontline workers.
- **View integration as an investment opportunity, not a cost saving venture.** Notwithstanding its uncertainty, use Welsh Government funding to embed integrated methods and develop innovative models of care to achieve seamless services. Recognise that integration can achieve greater efficiency and effectiveness.

- **Strike the right balance between structural and people factors.** Do not underestimate the importance of formal agreements, collaborative governance arrangements and good organisational structures but never lose sight of the fact that it is people who will ultimately make it happen. Give frontline staff permission to do their best for people through working together.
- **Accept that achieving an integrated way of working is mandatory not optional.** Cooperation between organisations is a statutory requirement and the Parliamentary Review's emphasis on seamless services points the way forward.
- **Draw on expertise to make it happen.** Ensure people who have traditionally been referred to as support staff such as Human Resources and Finance Officers from all the organisations involved are fully engaged with achieving the aims so that they can work together to overcome problems. Mandate them to find pragmatic ways of resolving difficult issues relating to staff and finance.

We would wish to conclude by offering a view on the role played by Welsh Government and the trade unions in achieving integration. We regard both as having a critically important contribution to make which, at the moment we would consider to be positive but open to improvement.

In the case of Welsh Government, laying the foundations for integration through statute, policy and funding has been fundamental. However, the implications of that funding via the Integrated Care Fund not being permanent is an inevitable barrier to local and regional bodies moving integration forward at the desired scale and pace. We acknowledge the positive messages Welsh Government officials have attempted to convey about the longevity of the funding and that integrated ways of working have been achieved despite the uncertainty, as exemplified in our case studies, but the interdependence of funding and the integrated approach must be recognised and sustained. Welsh Government must adopt a leadership role in ensuring that not collaborating and not integrating need to be the exception not the rule and levers, incentives and sanctions should be put in place which are geared towards ensuring this in practice. It should revisit the mechanisms it adopts around funding regimes so that funding can be accessed quickly, is routed appropriately, and is geared to delivering improvements.

The messages for the trade unions from this research relate to a need to escalate their supportive stance to one where they can be regarded as joint leaders of the integration agenda. Supporting staff through periods of change is a responsibility which trade union representatives are uniquely placed to fulfil. This cannot be properly achieved via a passive approach of "no objection" and needs to be based on representatives understanding the positive aspects of integrated working and the way it enriches the jobs of those involved. This can only be acquired through gaining increased knowledge of what integration means and doesn't mean and fuller engagement in the change process.

APPENDIX I · COMPENDIUM OF EXAMPLES OF INTEGRATION IN WALES

Project		Website / publication date	Source and date	Summary	Region
1	The Wallich Reflect to Perfect Group	2016	http://www.goodpractice.wales/SharedFiles/Download.aspx?pageid=96&mid=187&fileid=83	The Wallich is a supported housing organisation, working with homeless and vulnerable people across Wales. Enhancing the support offered by providing opportunities for our clients to learn new skills and to influence the service they receive.	All Wales
2	Cynefin in Cefn Mawr	2016	http://www.goodpractice.wales/SharedFiles/Download.aspx?pageid=96&mid=187&fileid=84	Cynefin is a Welsh Government programme which aims to improve the well-being of deprived communities across Wales. Eleven 'Place Coordinators' engage with the community, facilitate communication between all stakeholders, and empower the local residents to improve their quality of life.	All Wales
3	Llyn Parc Mawr Community Woodland Group	2016	http://www.goodpractice.wales/SharedFiles/Download.aspx?pageid=96&mid=187&fileid=92	Llyn Parc Mawr Community Woodland Group was established as part of the Cynefin programme that aims to explore new approaches to delivering long term improvements to the well-being of communities across Wales.	All Wales
4	Children's Commissioning Consortium Cymru (4Cs)	2016	http://www.goodpractice.wales/SharedFiles/Download.aspx?pageid=96&mid=187&fileid=96	A consortium of Welsh local authorities who collaborate in relation to commissioning placements for looked-after children.	All Wales
5	Cynefin in the Rhondda, Managing our Natural Resources	2016	http://www.goodpractice.wales/SharedFiles/Download.aspx?pageid=96&mid=187&fileid=97	Cynefin is a Welsh Government programme to improve the well-being of deprived communities across Wales. Eleven 'Place Coordinators' engage with the community, facilitate communication between all stakeholders, and empower the local residents to improve their quality of life.	All Wales
6	Numerous examples of integrated working in health and social care	2018	Report - The Parliamentary Review of Health and Social Care in Wales – A Revolution from within: Transforming health and care in Wales (2018)	Multiple integrated working examples	All Wales

Project		Website / publication date	Source and date	Summary	Region
7	Maelfa Health Centre Hub	2017	http://gov.wales/newsroom/health-and-social-services/2017/care-centres/?lang=en	Health Secretary Vaughan Gething announced plans to deliver nineteen new integrated health and care centres across Wales by 2021.	Cardiff and Vale
8	Cogan Hub Development	2017	http://gov.wales/newsroom/health-and-social-services/2017/care-centres/?lang=en	Health Secretary Vaughan Gething announced plans to deliver nineteen new integrated health and care centres across Wales by 2021.	Cardiff and Vale
9	Pentyrch Surgery	2017	http://gov.wales/newsroom/health-and-social-services/2017/care-centres/?lang=en	Health Secretary Vaughan Gething announced plans to deliver nineteen new integrated health and care centres across Wales by 2021.	Cardiff and Vale
10	City of Cardiff Council – Telecare Cardiff	2017	http://www.nhsconfed.org/-/media/Employers/Publications/WNHSC-Briefing-Integration-Briefing.pdf	Case Study.	Cardiff and Vale
11	Cardiff & Vale University Health Board (UHB)	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	Joint working programme examples	Cardiff and Vale
12	Wyn Campaign, Cardiff and the Vale of Glamorgan	2015	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4494466/	An invest-to-save scheme, serving a population of about half a million. Started in September 2011, it aims to provide wraparound services for frail older people including facilitated discharge, an alternative falls pathway for ambulances, in-reach support to care homes to prevent admission, improved case management for people with long-term conditions, and targeted step-up responses for frail older people.	Cardiff and Vale
13	Action in Caerau and Ely (ACE) Multi Agency Community Development	2016	http://www.goodpractice.wales/SharedFiles/Download.aspx?pageid=96&mid=187&fileid=90	ACE is a community development organisation based in the Ely & Caerau district of Cardiff. Working with community members and statutory and third-sector partners to build a sustainable, community-led regeneration charity which will have a positive impact on social, economic and health inequalities.	Cardiff and Vale

Project		Website / publication date	Source and date	Summary	Region
14	Single point of access (SPoA)	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	The Single Point of Access is a telephone-based Customer Contact Centre providing the mechanism for integrating locality social care and community health services to create a first point of contact for Health and Social Services across Cardiff and the Vale of Glamorgan.	Cardiff and Vale
15	Preventative Interventions	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	The service brings together a number of pre-existing and new services into a combined approach, streamlining access to information, support and advice to Cardiff residents to maintain their independence and reduce the need for long term care and support.	Cardiff and Vale
16	Accommodation Solutions	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	The Accommodation Solutions Team included Housing Re-settlement Officers and Occupational Therapists working with hospital staff to assess and plan for individual housing needs in preparation for their discharge.	Cardiff and Vale
17	Rapid Response Adaptation Programme (RRAP)	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	The Rapid Response Adaptation Programme (RRAP) was provided by Care and Repair Cardiff and Vale as part of the Accommodation Solutions Project.	Cardiff and Vale
18	Frail Older Persons Assessment and Liaison Service (FOPAL)	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	The FOPAL service places senior clinical expertise in complex geriatric medicine as close to the first contact in hospital as possible in order to prevent admission to hospital. The team liaises with intermediate care services to manage patients in their own homes. The benefits are well recognised and being embedded in many units in the UK.	Cardiff and Vale
19	Integrated Care Fund, Cardiff & Vale of Glamorgan	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	Partnership made up of the City of Cardiff Council, Vale of Glamorgan Council, Cardiff & Vale University Health Board, Welsh Ambulance Services NHS Trust, Third & Independent sectors and carer representatives.	Cardiff and Vale
20	Tonypandy Health Centre	2017	http://gov.wales/newsroom/health-and-social-services/2017/care-centres/?lang=en	Health Secretary Vaughan Gething announced plans to deliver nineteen new integrated health and care centres across Wales by 2021.	Cwm Taf

Project		Website / publication date	Source and date	Summary	Region
21	Dewi Sant Phase 2 development	2017	http://gov.wales/newsroom/health-and-social-services/2017/care-centres/?lang=en	Health Secretary Vaughan Gething announced plans to deliver nineteen new integrated health and care centres across Wales by 2021.	Cwm Taf
22	Mountain Ash Primary Care Centre	2017	http://gov.wales/newsroom/health-and-social-services/2017/care-centres/?lang=en	Health Secretary Vaughan Gething announced plans to deliver nineteen new integrated health and care centres across Wales by 2021.	Cwm Taf
23	Rhondda Cynon Taff County Borough Council - Reablement Service	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	The Reablement Assessment Team consists of five Occupational Therapists, four employed by the Council and one employed by the Cwm Taf Health Board, and two Physiotherapists, both employed by Cwm Taf Health Board.	Cwm Taf
24	Rhondda Cynon Taff County Borough Council - Learning Disability	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	Joint working in health and social care.	Cwm Taf
25	Rhondda Cynon Taff County Borough Council - Integrated Community Equipment Service	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	Rhondda Cynon Taf County Borough Council in partnership with Merthyr Tydfil County Borough Council and Cwm Taf Health Board established a formal partnership in 2008 via Section 33 of the National Health Service (Wales) Act which allows local authorities and NHS organisations to enter into partnership arrangements relating to pooled funding, joint commissioning and integrated provision of the community equipment service.	Cwm Taf
26	Glyncoch Community Regeneration	2016	http://www.goodpractice.wales/SharedFiles/Download.aspx?pageid=96&mid=187&fileid=86	The Glyncoch Community Regeneration charity was established by local community members as the vehicle for regeneration in Glyncoch and surrounding areas. It's a transformational organisation that hosts a Communities First programme, facilitates Oxfam's Sustainable Livelihoods initiative, and empowers individuals to have a voice in the services that affect them through Community Voice projects.	Cwm Taf

Project		Website / publication date	Source and date	Summary	Region
27	Getting Porth Connected	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	This pilot project, based in Porth, involves establishing strengths based community development approaches that focus on the assets of the community, engaging with the community and recruiting Community Connectors, people who know and understand their communities and are in touch with local citizens.	Cwm Taf
28	Care Home Support Team (CHST)	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	The purpose of the CHST is to work with the nursing home sector to identify those residents whose complex health needs may put them at risk of acute hospital admission. The team includes Medical, Nursing, Dietetic and Pharmacy staff input.	Cwm Taf
29	Project 5 “ways to wellbeing”	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	Third Sector innovation has been supported by Sharon Richards and Anne Morris, ICF leads for Cwm Taf. Their input into the ICF Third Sector stream has been critical in terms of enabling integration, applying step change at a strategic and operational level; with this support Project 5 ‘ways to wellbeing’ was born.	Cwm Taf
30	Complex Discharge Team Health and Social Care Discharge Coordinators	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	The Health and Social Care Discharge Coordinators support an Integrated Pathway Service and provide the point of contact at the hospital for the interface between secondary care and social care.	Cwm Taf
31	Early Supported Discharge Scheme for Stroke	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	“Together for Health – Stroke Delivery Plan” was published by Welsh Government in December 2012 and provides a framework for action by Local Health Boards and NHS Trusts working together with their partners to tackle stroke in people of all ages, wherever they live in Wales and whatever their circumstances.	Cwm Taf
32	Extended Reablement for People with Dementia	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	The service provides Reablement, short term support for individuals with Dementia or a cognitive impairment to regain or maintain skills and support to achieve levels of independence of ongoing service provision.	Cwm Taf

Project		Website / publication date	Source and date	Summary	Region
33	Community Coordinators	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	Cwm Taf Community Co-ordinators are the "go to" people for connection with services and activities for older people within the voluntary and community sector. This team of 5 comprises one Co-ordinator per locality (ie, Rhondda, Cynon, Taf, and Merthyr Tydfil) and one Co-ordinator to connect with Primary Care and Health.	Cwm Taf
34	Neighbourhood/Community Capacity Grant Scheme	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	The Grant Scheme was introduced as part of the original Cwm Taf portfolio of projects in 2014. The County Voluntary Councils (VAMT and Interlink) would take the lead on this part of the portfolio. With established contact with over 800 third sector organisations and community groups across the Cwm Taf.	Cwm Taf
35	The provision of additional social workers across Cwm Taf	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	The project outlines the provision of additional Social Workers to meet the demand for assessment and care management support to assist in hospital discharge.	Cwm Taf
36	Increased capacity within Intermediate Care, Reablement and Initial Response service	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	The project covers the increased capacity across Intermediate Care and Reablement. The Intermediate Care and Reablement service includes both Occupational Therapists and Physiotherapists who develop individualised programs of support to maximize a person's opportunity to remain living independently in their own homes.	Cwm Taf
37	Integrated Care Fund, Stay Well @home Service, Cwm Taf Region	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	Multidisciplinary hospital based team consisting of Social Workers, Occupational Therapists, Physiotherapists, Therapy Technicians commissioning a range of community based responses including packages of care, nursing support and medication assessment.	Cwm Taf
38	Tredegar Health and Wellbeing Centre	2017	http://gov.wales/newsroom/health-and-social-services/2017/care-centres/?lang=en	Health Secretary Vaughan Gething announced plans to deliver nineteen new integrated health and care centres across Wales by 2021.	Gwent
39	Newport East Resource Centre	2017	http://gov.wales/newsroom/health-and-social-services/2017/care-centres/?lang=en	Health Secretary Vaughan Gething announced plans to deliver nineteen new integrated health and care centres across Wales by 2021.	Gwent

Project		Website / publication date	Source and date	Summary	Region
40	Aneurin Bevan Health Board	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	Children's Services Joint Working	Gwent
41	Blaenau Gwent Locality Office Aneurin Bevan Health Board	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	Working in partnership alongside the Protection of Vulnerable Adults (POVA) co-ordinator Blaenau Gwent Social Services Department, social services, CSSIW, independent sector, and police.	Gwent
42	Blaenau Gwent Locality	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	Joint Working Health & Five Local Authorities	Gwent
43	Gwent-Wide Integrated Community Equipment Service (GWICES)	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	Joint arrangement between 5 Local Authorities and the Aneurin Bevan Health Board.	Gwent
44	The Gwent Frailty Programme	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	A joint project consisting of the five Local Authorities in the Gwent area and the Aneurin Bevan Health Board.	Gwent
45	Integrated Services for Older People in Monmouthshire	2016	http://www.goodpractice.wales/SharedFiles/Download.aspx?pageid=96&mid=187&fileid=80	Monmouthshire County Council and Aneurin Bevan University Health Board (ABuHB) have developed an Integrated Service for Older People focusing on early intervention and proactive health & well-being promotion.	Gwent
46	Bron Afon Community Housing	2016	http://www.goodpractice.wales/SharedFiles/Download.aspx?pageid=96&mid=187&fileid=89	Bron Afon Community Housing teamed up with Afon Youth to find solutions to issues around homelessness. The result being Tŷ Cyfle. A unique transition housing project designed by and for our young people.	Gwent

Project		Website / publication date	Source and date	Summary	Region
47	CARIAD – Step up/step down beds, Blaenau Gwent	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	This initiative put in place 4 intermediate care beds, with support through Community Resource Team (CRT) and managed domiciliary care hours with the aims being, to prevent unnecessary admission to hospital or long stay care and to provide support to unpaid carers.	Gwent
48	Monmouthshire Social care Model Development –Older People (including those with dementia)	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	This initiative recognizes the vital role that people play in planning and delivering care, across health, social services third sector, independent sector and informal carers – and so looks to develop and promote a relationship based experience of receiving care.	Gwent
49	Newport Older Persons Pathway	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	A joint initiative between Newport City Council and Aneurin Bevan University Health Board to develop an integrated pathway for older people in Newport who are identified through risk stratification as being at risk of admission to institutionalized care/becoming frequent users of high cost care.	Gwent
50	CRT Social work In-reach	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	This initiative was to put in place two social workers in the Blaenau Gwent Community Resource Team (CRT) with a focus on a pull model to facilitate timely discharge from hospital and reduce DToC, and connect to community service support.	Gwent
51	Torfaen Community Connectors	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	This initiative was to employ staff to be connectors in the community to support people through preventative interventions and so reduce demand to both social care and primary care.	Gwent
52	My Mates – Gwent (Greater Gwent Partnership Integrated Care Fund)	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	My Mates aims To provide opportunities for adults with a learning disability to form friendships and relationships in a supportive environment.	Gwent
53	Central Denbighshire Clinic / Hospital Redevelopment	2017	http://gov.wales/newsroom/health-and-social-services/2017/care-centres/?lang=en	Health Secretary Vaughan Gething announced plans to deliver nineteen new integrated health and care centres across Wales by 2021.	North Wales

Project		Website / publication date	Source and date	Summary	Region
54	Waunfawr Primary Care Centre	2017	http://gov.wales/newsroom/health-and-social-services/2017/care-centres/?lang=en	Health Secretary Vaughan Gething announced plans to deliver nineteen new integrated health and care centres across Wales by 2021.	North Wales
55	Conwy County Borough Council – The Extra Care Housing Scheme	2017	http://www.nhsconfed.org/-/media/Employers/Publications/WNHSC-Briefing-Integration-Briefing.pdf	Case Study.	North Wales
56	Betsi Cadwaladr University Health Board	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	Integrated Health & Social Care Teams	North Wales
57	Betsi Cadwaladr University Health Board	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	Joint working between health and social care	North Wales
58	Betsi Cadwaladr University Health Board	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	Joint working between health and social care	North Wales
59	Betsi Cadwaladr University Health Board	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	Joint working between health, social care, leisure services and 3rd sector.	North Wales
60	Betsi Cadwaladr University Health Board	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	Development of Integrated Locality Working – health and social services.	North Wales

Project		Website / publication date	Source and date	Summary	Region
61	Betsi Cadwaladr University Health Board and Wrexham CBC	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	An integrated approach in relation to Rehabilitation and Recovery services across Health and Social Care.	North Wales
62	Denbighshire Social Services - Hafan Lles Co-Located Multi Disciplinary Team	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	Hafan Lles (or Haven of Well-being) and is an innovative project which has brought together health, social care, housing and voluntary sector staff into one co-located centre. The project's main aim is to improve the health and wellbeing of older people in Prestatyn.	North Wales
63	Denbighshire - Disability integration project	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	This project is to integrate services for disabled children aimed at the co location of a multi agency team to work with disabled children and their families.	North Wales
64	Denbighshire - CAMHS Intervention Project	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	The aim of this project is to streamline the delivery of Child and Adult Mental Health Services (CAMHS) to children with emotional mental health needs. The project looks at CAMHS in the wider sense not just the service delivered by health. The project is being developed across both Conwy and Denbighshire local authorities and includes education and health covering both areas. The voluntary sector are involved in the project as Action for Children deliver family support services across both counties.	North Wales
65	Gwynedd County Council - Service Speciality: Adult Social Services	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	Partners in Care / Community Services Plan – Joint working including on Steering Group, Local Operational Groups, Multi-Disciplinary Teams (MDTs), "Partners in Care" developed from the Local Service Board's (LSB) multiagency vision to remodel community health and social care services in Gwynedd.	North Wales
66	Specialist Children's Services, Gwynedd Council	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	A multi-agency team with a joint Management Board comprising of nurses, psychologists, social workers, therapists, support workers etc.	North Wales

Project		Website / publication date	Source and date	Summary	Region
67	Isle of Anglesey Community Mental Health Service (CMHT) - Specialist Service for Clients with Mental Health Problems	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	Co-located integrated multi-disciplinary Community Mental Health team – Local Authority Social Services Department (LA SSD), Local Health Board (LHB) staff including: 7 Social Workers / 7 Community Psychiatric Nurses / 2 Occupational Therapists / Psychology / Psychiatrists / Admin support staff. Based in 2 LHB leased buildings.	North Wales
68	Isle of Anglesey and Betsi Cadwaladr University Health Board - Falls Prevention Service	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	The Falls Prevention Service on Ynys Môn was initially piloted for 9 months in the Amlwch catchment area in January 2009. The service was developed on a sound evidence base, and was delivered in the community in partnership between Physiotherapy and Leisure Exercise Professionals.	North Wales
69	Isle of Anglesey County Council - Complementary Purchasing Scheme for Health and Social Care	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	The complimentary purchasing scheme is a joint health and social care scheme that provides care in the homes of dependent patients who fit the criteria.	North Wales
70	Isle of Anglesey County Council - Tele-health Service	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	Telehealth provides a platform from which care and support can be provided to people to enable them to remain at home, safely, for as long as possible. A regional Telehealth Sub-group has been established, with representation from the 6 North Wales Local Authorities and the Health Board, to develop an effective Telehealth monitoring service across the region.	North Wales
71	Isle of Anglesey County Council - 24-hour Health and Social Care	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	The 24 Hour Health and Social Care Project provide a generic, integrated service to support service users in the community setting with health, enablement and social care support needs.	North Wales
72	Isle of Anglesey County Council - Intermediate Care	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working	Joint working / funding in health and social care.	North Wales

Project		Website / publication date	Source and date	Summary	Region
			%20examples%20between%20Health%20and%20Social%20Care.doc.		
73	Isle of Anglesey County Council - Joint Community Equipment Service	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	The integrated health and social service team includes a mix of skills across clinical disciplines and oversees the operational delivery of community based service. The disciplines have been integrated for over 10 years and are managed by one Service Manager which helps to facilitate the implementation of joint planning arrangements across Health and Social Services.	North Wales
74	WCBC Adult Social Care, Betsi Cadwaladr University Health Board, Supporting People, Housing Associations and Hafal - Registered Recovery Service for Adult Mental Health	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	A collaborative process between Wrexham Adult Social Care, Betsi Cadwaladr University Health Board, Supporting People, Housing Associations and the 3rd Sector (Hafal) to promote best practice.	North Wales
75	Gwynedd Council Direct Payment	2016	http://www.goodpractice.wales/SharedFiles/Download.aspx?pageid=96&mid=187&fileid=85	A new approach, harnessing the expertise, energy and commitment of people who use services and their carers to help improve the service. Direct Payments will focus on personal outcomes – what matters to people, what helps them live a good life. Systems and structures are being explicitly designed to support this relationship based approach.	North Wales
76	Age Well Hywliog Mon	2016	http://www.goodpractice.wales/SharedFiles/Download.aspx?pageid=96&mid=187&fileid=87	Age Well is a social enterprise and charity which helps the over 50s to improve their confidence and self-esteem, and stay healthy and active in mind and body. The Age Well initiative was initially set up as a three-year project to explore the need and establish activities for the over 50s in Anglesey. When the funding for the project came to an end the members decided unanimously to set up as a social enterprise in their own right.	North Wales

Project		Website / publication date	Source and date	Summary	Region
77	North Wales Cancer Forum	2016	http://www.goodpractice.wales/SharedFiles/Download.aspx?pageid=96&mid=187&fileid=91	The North Wales Cancer Network Patient Forum (CPF) is a voluntary group of people affected by cancer. The Forum enables the views and experiences of cancer patients, family and friends to be heard and used to actively influence the quality of cancer care by working in a positive partnership with health and social care teams and third sector organisations.	North Wales
78	Ffordd Gwynedd Health and Social Care	2016	http://www.goodpractice.wales/SharedFiles/Download.aspx?pageid=96&mid=187&fileid=93	Gwynedd Council and Betsi Cadwaladr University Health Board (BCUHB) have established an integrated health and social care team for older people – the Ffordd Gwynedd Health and Care team.	North Wales
79	Seiriol	2016	http://www.goodpractice.wales/SharedFiles/Download.aspx?pageid=96&mid=187&fileid=94	Building Communities Seiriol is a pilot project aimed at developing better relationships between communities and services providers in order to identify opportunities for co-producing services. The co-production approach has enabled partner organisations to work alongside community members, helping them to live the lives that they want and addressing the traditional power imbalance between user and provider.	North Wales
80	The Night Owls Service	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	The Night Owls service provides overnight care and support in Ynys Mon by Social Care Support Workers to enable older adults to remain living in their own home.	North Wales
81	Wrexham Intermediate Care Service	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	The Intermediate Care Service is an integrated, multi-disciplinary health and social care service. The service works across the hospital and community interface, and is supported by Occupational Therapists, Physiotherapists, District and Community Nurses, Social Workers, Generic Health and Social Care Workers and Homecare/ Reablement.	North Wales
82	Increased Support within ED & MAU	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	As part of the wider expansion of the Intermediate Care Service, Nurse Navigators' roles have been developed in order to support the effective and efficient throughput of cases; pulling people through the acute setting. These link workers are based within the Emergency Department (ED) and the Medical Assessment Unit (MAU).	North Wales

Project		Website / publication date	Source and date	Summary	Region
83	Community Agents	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	Community Agents are paid staff who work with older people, people with a learning or physical disability, and their carers, providing easy access to a wide range of information that will enable them to make informed choices about their present and future needs.	North Wales
84	Gwynedd Short Term Beds (Step up/down)	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	For the last two years ICF has funded enablement/recovery facilities across residential homes in Gwynedd with a total of 24 short term beds now fully operational. NOTE: The ICF only funds 8 beds and the remainder are funded either through paid respite service users or from core funding.	North Wales
85	Step Up Step Down Service, Flintshire	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	The purchase and provision of beds within care home settings where support can be provided to older people either to avoid hospital admission (step up) or support safe discharge where an individual is clinically able to leave a hospital with some support in a care based setting (step down). Staff elements within the service are for a small team of 2 social workers, a part time physiotherapist and an occupational therapist.	North Wales
86	Denbighshire Single Point of Access	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	SPOA is a streamlined way for adults and professionals across Denbighshire to gain direct access to information, advice, and assistance, and co-ordinated community Health and Social Care Services, by contacting one central, integrated team and number.	North Wales
87	Falls Team for Conwy	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	The falls team work collaboratively across organisations and professionals such as the intermediate care team, District Nurses, and local authority staff in SPoA; Occupational Therapist, Falls Coordinator and Community Wellbeing team as well as Third Sector partners.	North Wales
88	Conwy Community Wellbeing Team	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	The Conwy Community Wellbeing Team (CWT) was formed in December 2015 and has developed a co-ordinated, partnership approach to providing community activities in 5 health hub areas of Conwy.	North Wales
89	Building Communities and Local Asset Co-	2018	Report – Review of ICF (Intermediate Care Fund) –	An asset based approaches and co-production. An opportunity to 'develop a co-production project, and process, which will enable partner organisations	North Wales

Project		Website / publication date	Source and date	Summary	Region
	ordination, North Wales		Projects and initiatives which demonstrate good practice (2018)	to work together with the people living in our communities to live the lives that they want' and to address the imbalance between user and provider.	
90	Progression Support, North Wales	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	Assessment of people's independent living skills – enabling commissioning of services with an improved understanding of a person's independent living skills needed. Supporting the establishment of a multi-disciplinary team i.e. Occupational therapy and direct progression support staff.	North Wales
91	Machynlleth – reconfiguration and extension to create a primary and community care hub	2017	http://gov.wales/newsroom/health-and-social-services/2017/care-centres/?lang=en	Health Secretary Vaughan Gething announced plans to deliver nineteen new integrated health and care centres across Wales by 2021.	Powys
92	Llanfair Caereinion Primary Care Centre	2017	http://gov.wales/newsroom/health-and-social-services/2017/care-centres/?lang=en	Health Secretary Vaughan Gething announced plans to deliver nineteen new integrated health and care centres across Wales by 2021.	Powys
93	Powys Teaching Health Board – The Integrated Reablement Service	2017	http://www.nhsconfed.org/-/media/Employers/Publications/WNHSC-Briefing-Integration-Briefing.pdf	Case Study.	Powys
94	Powys Teaching Health Board and Powys County Council - Integrated Health and Social Care	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	Senior Partnership Manager appointed in June 2009 joint funded by PtHB and PCC and works within the framework of the Health Social Care and Wellbeing Partnership to plan integrated health and social care services.	Powys
95	Brecon Floating Support Services	2016	http://www.goodpractice.wales/SharedFiles/Download.aspx?pageid=96&mid=187&fileid=95	Cartrefi Cymru has been working with the people they support and Powys County Council to re-design Floating Support Service.	Powys

Project		Website / publication date	Source and date	Summary	Region
96	Powys Third Sector Broker Service	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	As part of an ICF funded portfolio of projects on the overall theme of Single Point of Access (Investing to go further), now called Powys People Direct, Powys Association of Voluntary Organisations (PAVO) initiated delivery of a Third Sector Broker Service.	Powys
97	Powys Befrienders Pilot Scheme (Crickhowell)	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	Powys Association of Voluntary Organisations (PAVO), through Powys Befrienders and the Powys Befrienders delivery partner Crickhowell Volunteer Bureau (CVB), was tasked with delivering a pilot project for a total of 35 registered clients, both current Day Care Centre (DCC) clients from the DCC in Crickhowell and new clients over the age of 60 in the surrounding areas, working alongside the services that they already receive to provide added benefit to their lives. In addition to CVB staff, the service was delivered by 11 trained volunteers.	Powys
98	Social Foot Care/"Simply Nails"	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	Simply Nails (or Social Footcare) is one of an ICF funded portfolio of third sector projects delivered under the auspices of Powys Association of Voluntary Organisations (PAVO) on the overall theme of Strengthening Community Capacity (Investing to join up).	Powys
99	Powys Regional Partnership Board – Assistive Technology	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	Multiple integrated working examples around assistive technology.	Powys
100	Local Area Coordination in Swansea	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	Supporting People to stay strong through friends, family and community. Long-term evidence based approach to supporting disabled people, people with mental health problems, older people and their families and carers to stay strong, safe and connected as contributing citizens.	Swansea
101	The Community Care Closer to Home project in Pembrokeshire	2018	https://www.kingsfund.org.uk/audio-video/co-ordinated-care-pembrokeshire-developing-community-resource-teams	This case study is part of a research project undertaken by The King's Fund and funded by Aetna and the Aetna Foundation in the United States to compare five successful UK-based models of care co-ordination.	West Wales

Project		Website / publication date	Source and date	Summary	Region
102	Aberaeron Integrated Care Centre	2017	http://gov.wales/newsroom/health-and-social-services/2017/care-centres/?lang=en	Health Secretary Vaughan Gething announced plans to deliver nineteen new integrated health and care centres across Wales by 2021.	West Wales
103	Fishguard Health Centre	2017	http://gov.wales/newsroom/health-and-social-services/2017/care-centres/?lang=en	Health Secretary Vaughan Gething announced plans to deliver nineteen new integrated health and care centres across Wales by 2021.	West Wales
104	Cross Hands Integrated Care Centre	2017	http://gov.wales/newsroom/health-and-social-services/2017/care-centres/?lang=en	Health Secretary Vaughan Gething announced plans to deliver nineteen new integrated health and care centres across Wales by 2021.	West Wales
105	Carmarthenshire County Council	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	Social Care, Health and Housing, Head of Primary, Community & Social Care Services for Carmarthenshire County Council & Hywel Dda Health Board (Carmarthenshire Division) and Development of an Integrated Management Structure for Health and Social Care.	West Wales
106	Carmarthenshire Generic Health and Social Care Worker	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	The aim of the project is to bring together the skills of the Local Authority Domiciliary Care Worker and the skills of the Health District Nurse.	West Wales
107	Ceredigion County Council, Health, Social Care and Wellbeing Services	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	Joint appointment of Joint Commissioning Manager and Health & Well-being Strategy Manager, Use of Joint Working Special Grant to fund Health, Social Care and Well-being Projects.	West Wales
108	Ceredigion County Council, Big Lottery Funded Activity	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	The programme entitled 'Iachus Gyda'n Gilydd / Healthy Together', has been developed by a partnership group of voluntary and statutory organisations under Ceredigion's Health and Well being Partnership.	West Wales
109	Ceredigion County Council, Local partnership funded	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working	Cylch Caron project –The lead partner in this project is Hywel Dda, but a joint programme board exists that is driving forward the work on developing an integrated health, social care and housing facility.	West Wales

Project		Website / publication date	Source and date	Summary	Region
	activity - Cylch Caron project		%20examples%20between%20Health%20and%20Social%20Care.doc.		
110	Ceredigion County Council, Local partnership funded activity - Fan Hyn Fan Draw	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	'Fan Hyn Fan Draw' - Representation from several partner organizations. The aim of the Project Group is to ensure that a wide range of services are made accessible to the communities within the project area.	West Wales
111	Ceredigion County Council, Local partnership funded activity - Service Integration & Improvement Programme	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	A Service Integration and Improvement programme agreed between Ceredigion County Council (CCC) Social Services and Hywel Dda.	West Wales
112	Ceredigion County Council, Local partnership funded activity - Integrated Community Equipment Facility	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	Integrated Community Equipment Facility. Pooled budget arrangements. Links have been established with Pembrokeshire and Carmarthen Integrated Community Equipment services to develop common areas of practice and protocols.	West Wales
113	Ceredigion County Council, Local partnership funded activity - The Ceredigion Investors in Carers (CiiC)	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	The Ceredigion Investors in Carers (CiiC): The award winning Ceredigion Investors in Carers (GP Practice Scheme) a tri-partite scheme with Hywel Dda Health Board and Voluntary sector partner now has its 15th Practice at Bronze level and 6 local authorities in Wales and England have purchased the Ceredigion developed CD Rom scheme. In neighbouring authorities Pembrokeshire have 3 surgeries at Bronze and Carmarthenshire have 8 working towards Bronze. The scheme in Ceredigion will shortly be piloting 5 surgeries to silver level. The scheme is noted as one of good practice by WAG.	West Wales

Project		Website / publication date	Source and date	Summary	Region
114	Ceredigion County Council, Local partnership funded activity -Cardian Rehab & GP Referral Schemes	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	Cardiac Rehabilitation and GP Referral Schemes have been established across the county's leisure centres as well as outreach venues for the past 5 years initially using Big Lottery Funding and thereafter funding from the Health Board and WAG.	West Wales
115	Ceredigion County Council, Local partnership funded activity - Ceredigion Carers Serviec & British Red Cross	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	Ceredigion Carers Service with British Red Cross: The quarterly Training and Events Programme continues to be delivered with a range of caring related topics and personal development, social interactive topics at venues across the county working in partnership with other agencies and groups.	West Wales
116	Ceredigion County Council, Local partnership funded activity - Joint Care Beds	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	Ongoing Ceredigion Joint Care Beds (JCB) service provided in partnership between Social Services and Hywel Dda Health Board in the provision of beds within the Local Authority's seven residential homes to prevent hospital admission or provide care upon discharge from hospital.	West Wales
117	Ceredigion County Council, Local partnership funded activity -Assistive Technology – CATH scheme	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	Assistive Technology – CATH scheme: has been rolled out throughout the county with an increase in clients to 153. Home Care provide responders during the day and an On call night time service. The service is managed on a multi agency basis – the Local Authority in conjunction with the Welsh Ambulance Trust and Fire Service.	West Wales
118	Ceredigion County Council, Local partnership funded activity - Weekly Video link	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	Weekly Video link between Ty Geraint Palliative Care Centre, Aberystwyth and Cardigan Hospital between Macmillan nurses, complimentary Therapists, OTs and Beacon of Hope, Case Workers to ensure cross agency support for both carers and patients.	West Wales

Project		Website / publication date	Source and date	Summary	Region
119	Pembrokeshire Health, Social Care and Well-being Partnership - Health, Social Care and Well-being	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	Joint appointment of Health, Social Care and Well-being Manager. Use of Joint Working Special Grant to fund Health, Social Care and Well-being Projects. The development of the Complex Care Teams, Chronic Conditions Nurse Practitioners and integrated community services has consistently reduced unnecessary hospital admissions.	West Wales
120	Pembrokeshire Health, Social Care and Well-being Partnership - Big Lottery Funded	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	The Family Challenge project, partly funded by the BIG Lottery Way of Life, provides a free intensive, whole family support programme designed to help families overcome many of the barriers they face to adopting a healthier lifestyle.	West Wales
121	Transforming Adult Social Care in Carmarthenshire	2016	http://www.goodpractice.wales/SharedFiles/Download.aspx?pageid=96&mid=187&fileid=98	In November 2012 Carmarthenshire County Council carried out a six-day review of Older Persons services, involving service users, carers and staff working in the community resulting in a more focused purpose, and a set of principles, looking at everything through the eyes of our service users. A multidisciplinary re-design team was brought together to pilot the Transforming Adult Social Care (TASC) project in Llanelli, before a county-wide rollout.	West Wales
122	Integrated Health and Social Care Worker Project (IHSCWP)	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)		West Wales
123	Pembrokeshire Intermediate Voluntary Organisations Team (PIVOT)	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	Pembrokeshire Intermediate Voluntary Organisations Team (PIVOT) was set up to further develop preventative, lower level, third sector services and develop a more robust commissioning framework with the third sector to prevent hospital admissions for frail older people and support re-ablement. PIVOT brings together five third sector organisations: Pembrokeshire Association of Community Transport Organisations (PACTO), Royal Voluntary Service, Age Cymru Pembrokeshire, British Red Cross and Pembrokeshire Care and Repair.	West Wales

Project		Website / publication date	Source and date	Summary	Region
124	Transfer Of Care Advice and Liaison Services TOCALS	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	Multi-disciplinary TOCALS teams were set up in PPH and GGH. The project was first established in PPH at the end of September 2014 and ran as a proof of concept before it was implemented in GGH in December 2014. The teams include social workers, physiotherapists, district nurses, and staff nurses.	West Wales
125	West Wales Care Partnership	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	Transfer of Care and Liaison Services (Carmarthenshire), Accessing Alternatives to Admission (Ceredigion), Multi Agency Support Team (Pembrokeshire).	West Wales
126	Penclawdd Health Centre	2017	http://gov.wales/newsroom/health-and-social-services/2017/care-centres/?lang=en	Health Secretary Vaughan Gething announced plans to deliver nineteen new integrated health and care centres across Wales by 2021.	Western Bay
127	Murton Community Clinic	2017	http://gov.wales/newsroom/health-and-social-services/2017/care-centres/?lang=en	Health Secretary Vaughan Gething announced plans to deliver nineteen new integrated health and care centres across Wales by 2021.	Western Bay
128	Bridgend Town Centre Primary Care Centre	2017	http://gov.wales/newsroom/health-and-social-services/2017/care-centres/?lang=en	Health Secretary Vaughan Gething announced plans to deliver nineteen new integrated health and care centres across Wales by 2021.	Western Bay
129	Swansea Wellness Centre	2017	http://gov.wales/newsroom/health-and-social-services/2017/care-centres/?lang=en	Health Secretary Vaughan Gething announced plans to deliver nineteen new integrated health and care centres across Wales by 2021.	Western Bay
130	Gwynedd Council – A collaborative Care Plan focused on what matters	2017	http://www.nhsconfed.org/-/media/Employers/Publications/WNHSC-Briefing-Integration-Briefing.pdf	Case Study .	Western Bay
131	Abertawe Bro Morgannwg University Health Board (ABMU HB) and Bridgend	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	Jointly funded posts.	Western Bay

Project		Website / publication date	Source and date	Summary	Region
	County Borough Council (BCBC)				
132	Swansea Integrated Working health and Social Care	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	Joint working in health and social care.	Western Bay
133	Time to Meet (T2M)	2016	http://www.goodpractice.wales/SharedFiles/Download.aspx?pageid=96&mid=187&fileid=78	Time to Meet (T2M) is a social network organised by people with learning disabilities, their friends, families and support staff in Swansea and Neath Port Talbot. It exists to help members build stronger social lives by sharing skills, interests and time.	Western Bay
134	NPT Homes	2016	http://www.goodpractice.wales/SharedFiles/Download.aspx?pageid=96&mid=187&fileid=79	NPT Homes has been working with tenants to co-design and co-deliver a new support service delivery model for people over the age of 55.	Western Bay
135	Maggie's Cancer Caring Centre, Swansea	2016	http://www.goodpractice.wales/SharedFiles/Download.aspx?pageid=96&mid=187&fileid=81	Maggie's offers free practical, emotional and social support to people with cancer and their family and friends. Built in the grounds of specialist NHS cancer hospitals, the Centres are social rather than medical spaces, designed to be warm, informal and welcoming. Professionals are on hand to offer a programme of support that has been shown to improve physical and emotional well-being, developed to compliment medical treatment.	Western Bay
136	Carmarthenshire Housing Services	2016	http://www.goodpractice.wales/SharedFiles/Download.aspx?pageid=96&mid=187&fileid=82	Carmarthenshire County Council Housing Services and Community First clusters have been working with Spice to establish a time bank intended to engage community members, build social networks, and lead to improved outcomes for individuals, organisations and the wider community.	Western Bay
137	Enhanced Hospital Discharge Services	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	Initially the project was a pilot in Llys Y Bryn (LYB) care home, focussing on transfer of tasks from Nursing to Senior Domiciliary Care Workers for Non Complex Wound Care. A full training plan has been developed and work led by a Clinical Lead Nurse will ensure Non Complex Wound Care training will	Western Bay

Project		Website / publication date	Source and date	Summary	Region
				be rolled out across the remaining 6 Local Authority residential care homes in Carmarthenshire by the end of 2016/17.	
138	Rapid Adaptations Service	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	Example of integrated working	Western Bay
139	Common Access Point comprising Health & Social Care Professionals including Mental Health and Third Sector Brokerage.	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	Example of integrated working	Western Bay
140	Residential Reablement	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	Example of integrated working	Western Bay
141	Western Bay Acute Clinical Teams	2018	Report – Review of ICF (Intermediate Care Fund) – Projects and initiatives which demonstrate good practice (2018)	Example of integrated working	Western Bay
142	Grŵp Gwalia	2016	http://www.goodpractice.wales/SharedFiles/Download.aspx?pageid=96&mid=187&fileid=88	Grŵp Gwalia housing association provides a range of services including supported housing for disabled and older people in Wales. They took part in a co-productive approach to service and workforce development – Developing Evidence-Enriched Practice (DEEP) – working in partnership with Swansea University, Joseph Rowntree Foundation (JRF) and the Institute for Research and Innovation in Social Services (IRISS).	Western Bay / All Wales

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143	ABM UHB (Bridgend, West Vale of Glamorgan, Neath Port Talbot [NPT], Swansea and Ystradgynlais)	2010	http://www.wales.nhs.uk/sitesplus/documents/829/Joint%20Working%20examples%20between%20Health%20and%20Social%20Care.doc.	Joint working between health and social care	Western Bay and Cardiff and Vale

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